

# **System-wide Case Management Project Summary Report to Steering Committee**

**February 17, 2010**

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## Project Participants

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- The System-wide Case Managers for their commitment to client-centered care and their dedication to these unique and developmental roles. The results presented in this report show the value of your efforts in serving these client populations.

Sincerely,

Barb Wheler  
Project Manager

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## Executive Summary

It is the expectation of Alberta Health and Wellness that each Alberta Health Services Zone establish a system-wide case management function within the Continuing Care continuum (Alberta Health and Wellness, 2008). In April 2006, Alberta Health and Wellness provided a Continuing Care Initiatives grant to each Zone to support efforts to meet the case management standard. Integrated Seniors Health - Calgary Zone utilized this funding to initiate the System-wide Case Management Project in July 2007. The project objective was to create, implement and evaluate a service model for System-wide Case Management with 4 pilot populations over an 18-month period and to use the project findings to operationalize System-wide Case Management in the Calgary Zone. The pilot populations, initially chosen based upon prevalence, complexity, and impact to the system were confirmed as the project progressed to include:

- Individuals with Amyotrophic Lateral Sclerosis (ALS)
- Individuals with Multiple Sclerosis (MS)
- Individuals with an early-stage Dementia
- Individuals with Brain Injuries or Mental Illness who required admission to a Personal Care Home, Designated Assisted Living facility, or care centre.

Benefits for the four pilot populations were anticipated at both the client/family and systems levels through a client-centred approach to the coordination of numerous health care providers and sectors across the system and over time. Knowledge exchange related to the specific disease processes and to the system itself was an integral component.

The System-wide Case Management service began accepting clients in April 2008. Service is provided by System-wide Case Managers without discipline-specific assessment or intervention responsibilities. The key functions of the System-wide Case Managers are:

- System navigation – identifying and facilitating access to the right service from the right provider at the right time
- Clinical consultation – exchanging knowledge related to respective disease processes and the continuum of services and resources to enhance client self-management and quality of care.

The roles of the System-wide Case Managers are diagnosis-specific and balance client outcomes with utilization of limited resources. They interact directly with clients, including family members and informal supports, and practice collaboratively with specialists and direct service providers across the Alberta Health Services continuum of care and the community. The mix of professional disciplines within the System-wide Case Management team, including Nursing, Occupational Therapy and Social Work, contributes to successful outcomes. Population-specific advisory groups are another essential support.

Quantitative data suggest that System-wide Case Management improves integration of the health care system for individual clients with complex needs:

- Emergency department, urgent care and acute care utilization is reduced (Dementia, ALS, MS)
- Access and admissions to services in the continuum of care are improved
  - Access and admissions to Personal Care Homes and Care Centres are successfully impacted (Brain Injury, Mental Health)
  - Patient flow between Calgary Zone and Halvar Jonson Centre – Central Zone is improved (Brain Injury)
- Completion of Advance Care Planning is increased (Dementia).

Client-related qualitative evidence shows that System-wide Case Management has a positive impact upon clients and families:

- Clients and families express satisfaction with the service and feel supported
- Clients and families continue to learn about the impact of disease
- Clients and families adjust to changes and prepare for the future
- Access is improved
- Informal resources are used effectively
- Alternative solutions are identified

Case management-related qualitative evidence shows that:

- Collaborative practice and knowledge exchange are improved
- System gaps and barriers are acknowledged
- System-wide Case Managers are satisfied with their roles and capability to provide integrated care to clients and families
- The multidisciplinary composition of the System-wide Case Management team was successful
- Education for System-wide Case Managers is broad
- Clinical practice supports are important.

Project recommendations include:

- Operationalize System-wide Case Management roles for individuals with an early dementia, ALS, and MS according to risk factors confirmed in this project
- Create System-wide Case Management roles for at-risk Brain Injury and Mental Health Populations
- Continue to foster expertise and collaborative practice in the care of individuals with an early dementia, ALS, MS, Brain Injury, and Mental Illness including:
  - Designate a core group of professionals within Continuing Care as responsible for case management of individuals with complex chronic conditions
  - Develop Case Management Quick Reference Guides specific to early dementia; ALS; MS; Brain Injury; and Mental Illnesses commonly encountered within Continuing Care
  - Identify strategies to further enhance communication along the service continuum in Dementia, MS, Brain Injury, Mental Health
- Continue partnerships with government ministries and community agencies to address specific gaps and barriers
  - Implement the National Alzheimer Society First Link program in the Calgary Zone
  - Create enhanced transition processes and environments for complex populations, specifically those under 65 years of age, within Continuing Care
  - Develop a Community Mental Health Consultation Team to support adults under 65 years of age within the Continuing Care stream.

## Project Background

Local and provincial influences prompted the creation of the System-wide Case Management Project in 2007 within the Calgary Zone of Alberta Health Services (AHS). Locally, individual service delivery sectors had long identified the existence of gaps along the continuum of care for long-term, complex populations. These gaps highlighted the need to assist clients and families to successfully navigate the complex health care system (Calgary Health Region, 2004). Provincially, client and family feedback also spoke loudly of gaps between health service sectors, particularly at times of transition to continuing care services (Alberta Health and Wellness and Continuing Care Leaders Council, 2007). Both levels concluded that these gaps result in unmet client needs, fragmentation of service delivery, and inefficient service provision and that quality improvement in patient, family, and health care provider/service experiences was required. Both the Calgary Zone and AHW identified that case management had the potential to contribute to these challenges (Calgary Health Region, 2004; Alberta Health and Wellness and Continuing Care Leaders Council, 2007).

To facilitate program planning and development, the Calgary Zone and the Continuing Care Leaders Council developed evidence-based case management frameworks. Case management definitions, principles and core elements appear in Appendix I. The two frameworks are congruent with one another and their content has since been affirmed by the Standards of Practice of the Canadian National Case Management Network (National Case Management Network, 2009).

It is the expectation of AHW that the former health regions establish a system-wide case management function at a continuing system level (Alberta Health and Wellness, 2008). In January 2007, AHW provided funding to support efforts to meet the case management standard. Integrated Seniors Health - Calgary Zone utilized this funding to create a System-wide Case Management Project. The objective was to create, implement and evaluate a service model for system-wide case management with 4 pilot populations over an 18-month period and to use the project findings to operationalize system-wide case management in the Calgary Zone.

Four pilot populations were chosen based on complexity, prevalence, and impact to the system. The pilot populations were confirmed as the project progressed to include:

- Individuals with Amyotrophic Lateral Sclerosis (ALS)
- Individuals with Multiple Sclerosis (MS)
- Individuals with an early-stage Dementia
- Individuals with Brain Injuries or Mental Illness who required admission to a Personal Care Home, Designated Assisted Living facility, or care centre.

Benefits for the four pilot populations were anticipated at both the client/family and systems levels through a client-centred approach to the coordination of numerous health care providers and sectors across the system and over time. Knowledge exchange related to the specific disease processes and to the system itself was an integral component of service delivery in the project.

A project manager was hired to design the services to be provided to the four populations and lead the implementation and evaluation. The remainder of the summary report includes the project schedule, resources, description of the service delivery model, summary of findings, and recommendations. Specific details related to each of the populations, including Planning Frameworks and Logic Models, appear in Appendices II through VIII.

## Project Schedule

- |                           |  |
|---------------------------|--|
| • July 2007               | Project Manager hired                                |
| • August – September 2007 | Population-specific Working Groups underway          |
| • January – August 2008   | 7 System-wide Case Managers hired                    |
| • April 2008              | First System-wide Case Management referrals accepted |
| • March 2009              | Evaluation Report completed                          |
| • April 2009              | Project extended to March 2010                       |
| • February 2010           | Project closed                                       |

## Project Resources

- The AHW Continuing Care Initiatives grant to the Calgary Zone provided funding equivalent to 8 full-time equivalents (FTE). This was allocated as follows:
  - Project Manager 1.0 FTE
  - System-wide Case Managers 6.0 FTE
  - Evaluation Consultant 1.0 FTE
- Managers within Integrated Home Care and Integrated Seniors Health & Transition Services assumed operational responsibility for the System-wide Case Managers and allocated infrastructure including desk space, cell phones, and laptop computers.

## System-wide Case Management Service Delivery Model

### *Role Description*

- A combination of integrated care (McGeehan and Applebaum, 2007) and strengths-based case management (Fast and Chapin, 2000) models guides System-wide Case Management service delivery.
- These are dedicated case management roles without profession-specific assessment/intervention responsibilities.
- The System-wide Case Managers interact directly with clients, including family members and informal supports, and practice collaboratively with specialists and direct service providers across the Alberta Health Services continuum of care and the community. Face to face contact, at least initially, is essential to client and professional relationship-building.
- The System-wide Case Managers key functions are:
  - system navigation – identifying and facilitating access to the right service from the right provider at the right time
  - clinical consultation – exchanging knowledge related to respective disease processes and the continuum of services and resources to enhance client self-management and quality of care.
- System-wide Case Management roles are diagnosis-specific.
- In keeping with case management principles, the role balances client outcomes with utilization of limited resources.

### *Inclusion/Exclusion Criteria*

- Criteria for System-wide Case Management services varied by population dependant on population needs (see Appendices X through XIII).

### *Process*

- The System-wide Case Management process (see Appendix IX) is evidence-based (Calgary Health Region,

2004; National Case Management Network, 2009) and includes:

- referral screening
- engagement
- assessment
- goal setting and care planning
- interventions
- monitoring and evaluation
- disengagement.
- Consistent System-wide Case Management practice elements across the populations include:
  - Referrals are screened according to inclusion/exclusion criteria.
  - The System-wide Case Managers identify and actively initiate communication with other direct service providers, including family physicians, to exchange relevant history and information.
  - Priorities and plans of action are negotiated with the client and family.
  - The frequency of monitoring and reassessments is determined by client and caregiver needs and the level of expertise of the direct service providers.
- Population needs precipitate some differences in practice across the populations. Differences include:
  - Dementia:
    - Telephone contact and 1 to 2 clinic visits to engage the client and family and then assess strengths and unmet needs occurs within 6 to 8 weeks of referral.
    - Home visits are conducted, if required, based upon established criteria.
    - The frequency of client contact varies significantly between clients and over time. It can be as little as every 3 months at times of stability and as often as daily during medical or psychosocial crises.
    - The majority of clients disengaged to date were transferred to the Integrated Home Care program due to increased professional and support service needs.
  - ALS:
    - Client/family engagement begins at disclosure of diagnosis.
    - Telephone contact and a home visit to reinforce and clarify information and initiate assessment of client and family strengths and needs occur within 2 weeks of referral.
    - Face-to-face contact, home and site visits are essential to client and professional relationships and accurate understanding of client function and living/care environments.
    - The frequency of client contact varies significantly between clients and over time. It can be as little as monthly during early stages of the disease and as often as daily during critical or end stages.
    - Bereavement visits are conducted as part of the disengagement of families following each client's death.
  - MS:
    - Telephone contact and a home visit to engage the client and family and then assess strengths and unmet needs occur within 6 to 8 weeks of referral.
    - Face-to-face contact, home and site visits are essential to client and professional relationships and accurate understanding of client function and living/care environments.
    - The frequency of client contact varies significantly between clients and over time. It can be as little as every 3 months at times of stability and as often as daily during medical or psychosocial crises.
  - Brain Injury and Mental Health:
    - Thorough chart review and active engagement of the client and family and direct service providers are an exceptionally lengthy and complex process. Most individuals have long histories of multiple acute and community care admissions, complex family dynamics, and multiple direct service providers. The integration of this information provides valuable insight into the strengths of clients and their informal supports and clarifies present care needs.
    - Face-to-face contact and site visits are essential to client and professional relationships and accurate understanding of client function and care environments.

- The System-wide Case Managers synthesize their findings to generate recommendations regarding priorities and plans of action to prepare for and eventually support a successful admission to Personal Care Home, Designated Assisted Living, or care centre.
- Once the individual stabilizes in the supportive or facility environment, case management responsibilities are transferred to the primarily responsible health care professional in that stream of care.

### ***Staffing***

- Nursing and Allied Health professions possess suitable skill sets for System-wide Case Management roles. Each profession provides a unique and valuable perspective.
- The mix within the multi-disciplinary System-wide Case Management team contributes to successful implementation of the roles. This mix is as follows:
  - Dementia
    - Registered Nurse
    - Registered Social Worker
  - ALS
    - Registered Occupational Therapist
  - MS
    - Registered Nurse
    - Registered Social Worker
  - Brain Injury and Mental Health
    - Registered Occupational Therapist
    - Community Rehabilitation Specialist
- Experience with the respective client population and with community practice is essential to the execution of these roles.

### ***Practice Supports***

- The System-wide Case Managers utilize patient information systems in acute, ambulatory and community care streams. These systems include:
  - Sunrise Clinical Manager (SCM)
  - Clinibase
  - ALS Clinic Access database
  - Community Care Information System (CCIS)
  - Pathways
- The System-wide Case Managers register their clients in the Community Care Information System (CCIS).
- Client documentation is completed primarily in CCIS Casenotes which are printed and faxed as needed to facilitate interprofessional communication.
- Entries are made in the acute care patient record and Integrated Home Care program main chart when indicated.
- An advisory group of key stakeholders along each population's care continuum meets with the System-wide Case Managers and Project Manager on a regular basis. The purpose is to inform the ongoing development and evaluation of the System-wide Case Management roles. Group members' guidance and recommendations are based upon their respective knowledge of service gaps and barriers, clinical issues, challenges and needs, and evidence-based practice.
- The System-wide Case Manager – ALS, ALS Clinic Facilitator, Respiratory Therapist and Social Worker, and ALS Society Client Service Coordinator meet monthly to problem-solve client issues.
- The System-wide Case Managers – MS meet weekly with MS Clinic staff for the same purpose.

### ***Caseload***

A summary of caseload data extracted from the Community Care Information System Central Index and Referral modules appears in Tables 1 and 2 below.

**TABLE 1. Caseload as of November 2009**

Descriptor	Dementia	ALS	MS	BI/MH
<b>Total # of clients on caseload</b>	94	60	95	87
<b>Caseload: Case Manager #1</b>	46	74	45	57
<b>Caseload: Case Manager #2</b>	48	-	50	30
<b>No. of Unique Clients Served</b>	117	74	96	123

**TABLE 2. Client Descriptors by Pilot Population (November 2009)**

	Dementia n = 117	MS n = 96	BI/MH n = 123	ALS n = 74
Gender				
<b>Female</b>	73 (62%)	66 (69%)	37 (30%)	31 (52%)
<b>Male</b>	44 (38%)	30 (31%)	86 (70%)	29 (48%)
<b>No Data</b>	0	0	0	0
Age				
<b>Average age</b>	79	52	54	63
<b>Age range</b>	53-94	24-80	19-92	41-87
<b>&gt;18 &lt;65</b>	3 (3%)	87 (91%)	99 (80%)	29 (39%)
<b>65+</b>	114 (97%)	9 (9%)	24 (20%)	45 (61%)
Language				
<b>English</b>	72 (62%)	70 (73%)	97 (79%)	54 (73%)
<b>Other</b>	8 (6%)	1 (1%)	10 (8%)	5 (7%)
<b>No Data</b>	37 (32%)	25 (26%)	16 (13%)	15 (20%)
Marital Status				
<b>Married/Common law</b>	63 (54%)	39 (41%)	14 (11%)	43 (58%)
<b>Divorced/Separated</b>	8 (7%)	18 (19%)	35 (28%)	12 (16%)
<b>Single</b>	1 (1%)	13 (14%)	43 (34%)	3 (4%)
<b>Widowed</b>	26 (22%)	5 (5%)	8 (7%)	5 (7%)
<b>No Data</b>	19 (16%)	21 (22%)	24 (20%)	11 (15%)
Living Status				
<b>Lives with others</b>	68 (58%)	58 (60%)	51 (41%)	39 (54%)
<b>Lives alone</b>	16 (14%)	16 (17%)	7 (6%)	7 (9%)
<b>Group setting</b>	2 (2%)	6 (16%)	51 (41%)	4 (5%)
<b>No data</b>	31 (26%)	16 (17%)	14 (12%)	24 (32%)
Residence Type				
<b>Single family</b>	62 (53%)	65 (68%)	24 (20%)	53 (72%)
<b>Multiple person</b>	9 (8%)	3 (3%)	5 (4%)	2 (3%)
<b>Seniors Apartment</b>	17 (15%)	0 (0%)	0 (0%)	1 (1%)
<b>Care home (PCH)</b>	0 (0%)	2 (2%)	28 (23%)	0 (0%)
<b>Private Assisted Living/     Designated Assisted Living</b>	2 (0%)	0 (0%)	4 (3%)	1 (1%)
Continuing Care (RN on site)	3 (3%)	5 (5%)	34 (27%)	4 (5%)
<b>Homeless</b>	0 (0%)	0 (0%)	2 (2%)	0 (0%)
<b>No data</b>	24 (21%)	21 (22%)	26 (21%)	13 (18%)

## Workload Measurement

The System-wide Case Managers enter their own workload measurement data into the Community Care Information System Activity Recording module. A summary of the data recorded between February 2009 and October 2009 is provided in Appendix XIV.

## Project Findings

Findings from the System-wide Case Management Evaluation (Calgary Health Region, 2009) and other quantitative and qualitative data (including case examples in Appendices X through XIII) gathered to date shows that System-wide Case Management yields positive outcomes for the system and for individuals and their families within the four pilot populations. In addition, much has been learned about case management and a system-wide case management model.

### 1. System-wide Case Management improves integration of the health care system for individual clients with complex needs.

#### a) Acute Care Utilization is reduced (Dementia, ALS, MS).

A comparison of acute care utilization for individual clients for a period of at least six months pre and post System-wide Case Management involvement identified a reduction in emergency department and urgent care visits for Dementia, ALS and MS caseloads. Inpatient visits for these populations were limited but fewer visits were recorded after admission to the System-wide Case Management service (see Table 3).

**Table 3. Acute Care Utilization\***

SWCM Population	Total ED/UCC Visits	Before SWCM Admission	After SWCM Admission
Dementia	32	28	4
MS	60	43	17
ALS	39	27	12
	Total Inpatient Visits	Before SWCM Admission	After SWCM Admission
Dementia	6	5	1
MS	27	21	6
ALS	17	10	7

\*Individual visits within 6-12 months of admission to System-wide Case Management (as compared to same time period prior to admission)

SWCM – System-wide Case Management

ED – Emergency Department

UCC – Urgent Care Centre

#### b) Access and admissions to services in the continuum of care are improved

##### i) Admissions to Personal Care Homes and Care Centres are successfully impacted (Brain Injury and Mental Health)

The total number of admissions to Personal Care Home and Care Centre was relatively small during the project period but significant (see Table 4). Of greater significance was the success rate of these admissions. Fifty per cent of these individuals had a history of multiple failed placements prior to System-wide Case Management involvement. Current data indicates a ninety per cent success rate in the admissions to Personal Care Home, Designated Assisted Living and Care Centre supported by the System-wide Case Managers.

**Table 4. Admissions of System-wide Case Management Clients to Integrated Supportive & Facility Living (March 2008 to October 2009)**

	Mental Health	Brain Injury	Total
Personal Care Home	8	17	25

Designated Assisted Living	1	0	1
Care Centre	7	5	12

- ii) Patient flow between Calgary Zone and Halvar Jonson Centre – Central Zone is improved (Brain Injury)

While the number (6) is small, the data indicates more Calgary individuals were able to participate in the rehabilitation program at Halvar Jonson Centre as compared to the same time period without System-wide Case Management support (see Table 5). Timely discharges from the Halvar Jonson Centre program facilitate acceptance of new rehabilitation patients from Calgary Zone acute care and enable individuals to receive the right service in the right place at the right time.

**Table 5. Discharges from Halvar Jonson Centre to Calgary Zone**

	Home	MBIP*	Other PCH	Care Centre	Awaiting Care Centre RCTP	Fanning Neurorehab Unit	Acute Care (medically unstable)	Other	Total
<b>July 2006 to February 2008</b>	9	2	0	1	0		4	2	<b>21</b>
<b>March 2008 to October 2009</b>	12	7	1	0	3	1	1	Lodge - 1 Moved out of region - 1 Deceased - 1 1 – moved out of region	<b>27</b>

\* formerly the Transitional Brain Injury Project

MBIP – Mobile Brain Injury Program

PCH – Personal Care Home

RCTP – Regional Community Transition Program

- c) **Integration of the continuum of services for individual clients with complex needs is improved (all). To achieve this, System-wide Case Managers:**

- Utilize a broad view of the continuum of services (Calgary Health Region, 2009, p. 26)
- Identify, acknowledge and improve understanding of system gaps and barriers. The System-wide Case Managers were able to identify and articulate gaps and barriers in the continuum of services to the appropriate people, for example, flexible respite options. Barriers to access are often a symptom of systemic issues, for example, limited available resources.
- Establish collaborative relationships and bridge the many services available to clients (Calgary Health Region, 2009, p.25) including acting as conduits of information along the continuum of care and across services.
- Search for alternatives for clients and act as advocates and negotiators for clients for whom services are scarce or non-existent.
- Improve client access to services, and assist with the integration and coordination of appropriate services for clients and their families or informal caregivers (Calgary Health Region, 2009, p.6).

## 2. System-wide Case Managers have a positive impact on clients and families.

### a) Improved completion of Advance Care Planning (Dementia)

Approximately 60% of the individuals with a dementia referred to System-wide Case Management had either not initiated or not fully completed ACP documents. Many individuals were uncertain which components were outstanding. Of those with completed documents, a significant number:

- were unaware of the intent/scope of the documents
- had not updated the documents nor communicated to the individuals named in the documents
- did not know where the documents were stored.

The System-wide Case Managers (Dementia) consistently explore ACP with clients and caregivers. The majority (83%) of System-wide Case Management clients completed ACP discussions and documents with their families and/or made required revisions to existing documents. Clients and caregivers have maximal input into future care decisions and accurate, up-to-date information is available at times of transitions between care streams.

**b) Clients and families express satisfaction with the service and feel supported (Calgary Health Region, 2009, p. 26- 27)**

**c) Client and families continue to learn about the impact of disease (see Appendices X through XIII)**

Client and family education is an essential System-wide Case Management intervention. Clients and families consistently benefit from ongoing reinforcement of disease-related information at a pace that matches their readiness to receive it. Both also benefit from ongoing support to apply that information to practical day-to-day challenges as they change. The System-wide Case Managers openly address behavioral and cognitive changes and problem-solve effective strategies and adaptations. The System-wide Case Managers adapt communication with clients to maximize their participation in their care. The System-wide Case Managers also connect directly with families and substitute decision-makers to exchange client and health system information. Their client-centered approach and long term involvement allow the System-wide Case Managers to reinforce information, clarify options and facilitate informed decision-making.

**d) Clients and families are supported to adjust to changes (see Appendices X through XIII)**

The System-wide Case Managers encounter individuals and families in varying stages of grief and adjustment to the inevitable losses attributable to progressive disease. The System-wide Case Managers facilitate goal-setting and interventions to maximize participation in daily life and support the client and family's ability to cope as care needs change. The therapeutic relationship that develops over time creates opportunities to revisit issues and enables discussions about what support can look like, about how refusal of support is influencing daily life, and about how the client or family might recognize when it is time to try a different approach.

**e) Informal resources are used effectively (see Appendices X through XIII)**

The System-wide Case Managers influence effective utilization of informal resources through their in-depth understanding of individual client and family strengths and needs, of the disease process, and of the available services and programs. Over the duration of the project, there were multiple scenarios in which this reduced caregiver burden, client risk, and the likelihood of crisis. The System-wide Case Managers' involvement over time occasionally leads to the disclosure of significant clinical information such as substance use, aggressive behaviors, and/or unsafe living conditions. The System-wide Case Managers facilitate the integration of this information into more successful plans of care.

**f) Alternative solutions are identified (see Appendices XI through XIII).**

In a system of limited resources, there are times when compromise solutions are required. By assisting clients and families to clarify what would be helpful and fully exploring what is available, the System-wide Case Managers are able to work with other direct service providers to find creative solutions.

### **3. Much was learned about the design and implementation of an innovative system-wide case management model.**

#### **a) Collaborative practice and knowledge exchange are improved (see Appendices X through XIII)**

The System-wide Case Managers partner directly with clients, families and other direct service providers. Their client-focused approach and ability to practice collaboratively across the continuum keep clients and families at the centre of care and facilitates knowledge exchange and communication across traditional program and service boundaries. The System-wide Case Managers support Individual direct service providers to expand their understanding of the individual client and their actual needs and add to their knowledge of the disease process. Direct service providers become more aware of each other's involvement and are supported to work together to identify practical solutions and strategies to meet care needs with available resources.

#### **b) System-wide Case Managers are satisfied with their roles and capability to provide integrated care to clients and families.**

- System-wide Case Managers found it satisfying to acquire an in-depth knowledge about the specific pilot population disease (Calgary Health Region, 2009, p. 26).
- Problem solving related to system gaps and barriers was satisfying (Calgary Health Region, 2009, p. 26)
- System-wide Case Managers found it satisfying to assist clients in taking responsibility for their actions and decisions which is an integral principle of the strengths based approach (Calgary Health Region, 2009, p. 26)
- Advocacy, building relationships, documenting, education and finding or connecting resources were identified as important and sometimes challenging functions
- The role often involves challenging current system practices
- System-wide Case Managers are seen as change agents

#### **c) The multidisciplinary composition of the System-wide Case Management team was successful.**

System-wide Case Managers from different disciplines allow a cross exchange of knowledge and ideas to the benefit of clients and health care professionals

#### **d) Education for System-wide Case Managers is broad.**

- System-wide Case Management education needs to include elements that support advocacy, client adherence, relationship building, communication and negotiation. In addition, communicating with clients about goals and goal setting is important as a support for care planning.
- System-wide Case Managers indicated a preference for strengths-based approach as it promotes both a client centered focus and a goal setting process.

#### **e) Clinical practice supports are important.**

- Working across traditional programs and boundaries means more collaboration, more perspectives to understand, and multiple mandates to reconcile. System-wide Case Management practice requires:
  - More highly developed than anticipated communication, negotiation, consensus-building, and advocacy skills.
  - Greater than anticipated manager and director-level support of System-wide Case Managers' role in identifying gaps and barriers and advocating for system change.
- Regular meetings of the System-wide Case Managers provided opportunities for collegial support. Collegial support facilitated ongoing improvements and solutions
- The project manager played a significant role in supporting the System-wide Case Managers in the case management role (Calgary Health Region, 2009, p. 16).

- Working groups were an essential structure for the development, support and evaluation of the System-wide Case Management roles. The breadth of stakeholder representation was a critical feature.

**f) Other**

- Education and marketing of this new service required more time than anticipated. It required a significant change in practice for many referral sources and it was challenging to describe a non-traditional role that did not work *for* a particular program but *with* multiple programs.
- At the time of the March 2009 evaluation most of the healthcare professionals interviewed valued System-wide Case Management while a small minority of health care professionals found the role confusing and a duplication of service
- The System-wide Case Management roles evolved over the duration of the project. While they started with specific diagnostic groups, the role is generalizable to other complex client populations.
- The Activity Recording data extracted from the Community Care Information System provides some insight into System-wide Case Management practice.
  - On average, 32% of the System-wide Case Managers time was spent in activity related to specific individual clients.
  - Another 20% was spent in case management activities which related to a group of clients or the caseload itself. Such activities include multidisciplinary rounds, relationship building, diagnosis-related education, documenting gaps and unmet needs and addressing barriers. Time spent navigating individuals to the right service, if System-wide Case Management was not, is reflected here.
  - Remaining time was spent on travel (21%) and non-client related activity (27%).
- The ideal caseload size is not known and is dependent on multiple factors

## Project Recommendations

1. Operationalize System-wide Case Management for individuals with an early dementia, ALS, and MS according to risk factors confirmed in this project (see Appendices X, XI and XII).
2. Create System-wide Case Management Roles for at-risk Brain Injury and Mental Health Populations (see Appendix XIII).
3. Continue to foster expertise and support collaborative practice in the care of individuals with an early dementia, ALS, MS, Brain Injury, and Mental Illness
  - a. Designate a core group of professionals within Integrated Home Care and Integrated Supportive & Facility Living to be responsible for case management of individuals with complex chronic conditions (see Appendix X, XI, XII and XIII).
  - b. Develop Case Management Quick Reference Guides specific to:
    - early dementia (see Appendix X)
    - ALS (see Appendix XI)
    - MS (see Appendix XII)
    - Brain Injury (see Appendix XIII)
    - Mental Illnesses commonly encountered within Continuing Care (see Appendix XIII).
  - c. Explore strategies to enhance communication along the service continuum in Dementia, MS, Brain Injury (see Appendix X, XII and XIII)
  - d. Support strategies that strengthen relationships and communication between community Mental Health and Continuing Care (see Appendix XIII)

- e. Re-establish a networking forum for the MS Service Continuum (see Appendix XII)
  - f. Establish an ongoing networking forum for the Brain Injury Continuum (see Appendix XIII).
4. Continue partnerships with government ministries and community agencies to address specific gaps and barriers
- a. Implement the National Alzheimer Society First Link program in the Calgary Zone (see Appendix X)
  - b. Create enhanced transition processes and environments for complex populations, specifically those under 65 years of age, within Continuing Care (see Appendix XIII)
  - c. Develop a Community Mental Health Consultation Team to support adults less than 65 years of age within the Continuing Care stream (see Appendix XIII).

## Formal Acceptance of Deliverables and Project Closure

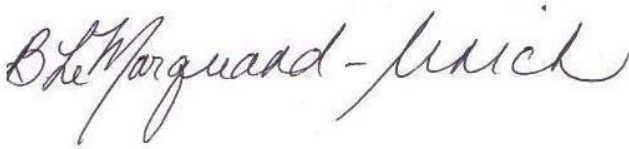
The signatures below indicate the undersigned accept the contents of this Close-out Report and Attachments and agree that this project is formally closed.



Project Manager

February 17, 2010

Date



Project Sponsor

February 26, 2010

Date

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## Glossary

**Dealing with Dementia Program** – an education and management program sponsored by the Carewest Day Hospital for individuals living with dementia and their caregivers

**Memory P.L.U.S. (Practice, Laughter, Useful Strategies)** – a community-based social program sponsored by the Family Caregiver Center to enable people diagnosed with mild dementia and their caregivers to connect with others experiencing similar challenges.

**Living with Dementia** – an information and support group sponsored by the Alzheimer Society – Calgary for those with early dementia.

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## References

Alberta Health and Wellness (2008). *Alberta Continuing Care Health Service Standards*.

Alberta Health and Wellness and Continuing Care Leaders Council (2007). *Case Management for Continuing Care Clients (Draft)*.

Calgary Health Region (2009). *System-wide Case Management Evaluation Report*.

Calgary Health Region (2006). *Multiple Sclerosis: A Profile of Clients and Review of Services Provided by Home Care and Supported Living*.

Calgary Health Region (2005). *Calgary Brain Injury Strategy: Foundations for Direction*.

Calgary Health Region (2004). *Framework for Case Management*.

Canadian Home Care Association (2005). *Case Management: A Strategy for Health Systems Integration*. CHCA Position Paper, October.

Case Management Society of America (2005). *Standards of Practice for Case Management*.

Fast, B. and Chapin, R. (2000). *Strengths-based Care Management for Older Adults*. Health Professionals Press, Incorporated.

McGeehan, S.K., Applebaum, R. (2007). The Evolving Role of Care Management in Integrated Models of Care. *Care Management Journals*, 8(2), 64-70.

McMaster University - Centre for Continuing Education (2008). *Supporting Systems Integrations through Case Management: Participant Workbook* developed for Alberta Health and Wellness.

National Case Management Network (2009). *Canadian Standards of Practice for Case Management*.

## Appendix I

### Case Management Definition, Principles and Core Elements

Case management is:

a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.

(Case Management Society of America, 2005)

Case management principles include:

- Client-centeredness
- Navigation
- Collaboration/coordination
- Health promotion/prevention
- Quality of care
- Resources management
- Communication
- Advocacy
- Discretionary judgment
- Flexibility
- Education of client/family

(Calgary Health Region, 2004; Alberta Health and Wellness and Continuing Care Leaders Council, 2007)

The case management process includes:

- Identification and selection for case management services
- Assessment
- Problem identification
- Care/service planning
- Care implementation/coordination of services
- Monitoring/evaluating care and outcomes
- Reassessment
- Disengagement

(Calgary Health Region, 2004; Alberta Health and Wellness and Continuing Care Leaders Council, 2007)

## Appendix II

### Dementia System-wide Case Management Logic Model

Main Components	Intake	Assessment/Care Planning	Intervention	Monitoring/Evaluation	Transition
<b>Implementation Objectives</b>	To ensure the clients/caregivers referred to the pilot project provide a representative sample.	To create and trial an assessment process that supports identification of needs and goal setting. To work with clients/caregivers to identify opportunities to meet identified goals.	To facilitate client/caregiver access to services based on identified needs/goals.	To establish and evaluate parameters for follow-up with clients/caregivers.	To facilitate when appropriate a positive hand-off to another case manager in the system.
<b>Implementation Strategies</b>	<ul style="list-style-type: none"> <li>Create a process map and referral form/criteria to guide the referral process.</li> <li>Provide education sessions to staff in the four referral source areas about the pilot.</li> <li>Screen all referrals as per process map for appropriateness and document reasons for acceptance or denial.</li> </ul>	<ul style="list-style-type: none"> <li>Utilize the CDR as the basis of assessment.</li> <li>Incorporate screening tools (behavior checklist, GDS, safety/IADL, Zarit – caregiver burden) to trigger actions related to known risk factors.</li> <li>Utilize RRIT to gather demographic data and provide information to stratify population according to risk.</li> <li>Develop and trial a “dementia care guide” for the early phase of the disease to articulate interventions available for identified needs/goals.</li> </ul>	<ul style="list-style-type: none"> <li>Facilitate interventions based on documented care plan.</li> <li>Refine “dementia care guide” based on feedback from client/caregivers and other service providers.</li> </ul>	<ul style="list-style-type: none"> <li>Maintain contact with client and/or caregiver as per care plan utilizing phone follow up as appropriate.</li> <li>Re-assess client/caregiver as per care plan and/or at established intervals.</li> </ul>	<ul style="list-style-type: none"> <li>Ensure all client/caregiver information is shared with receiving service prior to transition.</li> <li>Maintain client/caregiver on caseload until relationship with new case manager is well established.</li> </ul>
<b>Outputs</b>	# of referrals by source # of referrals accepted into pilot # of referrals denied and reason Time spent processing referrals Satisfaction of client/caregivers and clinicians with process	# completed assessments # clients by stage RRIT scores # clients with caregiver available to complete CDR # completed care plans Satisfaction of clients/caregivers and clinicians with process/tools.	# referrals to programs/services by type # people attending recommended programs Actual time spent/client to facilitate interventions Adherence to guidelines Satisfaction of client/caregivers with available program/services Baseline and 6 month survey of emotional well-being and social function.	# clients on caseload # of contacts by type/client Actual time spent/client for monitoring/re-assessment. # re-assessments # and type of changes to care plan based on re-assessment	# individuals transitioned to another case manager and reason Satisfaction of client/caregiver and clinicians with transition process.
<b>Short-Term Outcomes</b> <b>1 year</b> <b>(Jan 2008-2009)</b>	Refinement of referral process/criteria based on satisfaction feedback. Creation of profiles of the type of clients referred by the various service areas and identification of gaps for clients not accepted to pilot project.	Data from RRIT and clinical assessment tools supports the creation of profiles of the population and identification of factors that indicate those at increased risk for inappropriate service utilization. Refinement of assessment and care planning process/tools based on satisfaction feedback.	Increased adherence to clinical guidelines as compared to literature. Participation in education/support programs meets and/or exceeds targets. Improvement in emotional well-being and social function. Recommendations for future direction of service informed by satisfaction feedback.	Recommendations regarding caseloads are developed based on pilot project data.	Qualitative feedback identifies key factors related to successful transitions.
<b>Long Term Outcomes</b> <b>2-3 years</b> <b>(Jan 2009-2011)</b>	<i>Improved Satisfaction of client/caregivers and clinicians with the ability of the system to meet the needs of individuals recently diagnosed with dementia. Improvement in identified key indicators (TBD).</i>				
<b>Impact</b> <b>3-5 year</b> <b>(Jan 2011-2013)</b>	<i>Quality of life for individuals recently diagnosed with dementia and their caregivers is enhanced through the provision of effective and proactive interventions. Existing services have increased capacity to meet the needs of individuals with dementia and their caregivers.</i>				

## Appendix III

### ALS System-wide Case Management Planning Framework - Revised

Issues	Client Needs	Strategies	Target Population
ALS is a progressive, degenerative disease culminating in respiratory insufficiency and death <sup>1</sup>	Clients and families require an effective, timely and coordinated effort to facilitate and integrate care across the continuum from diagnosis to death.	Develop, implement and evaluate a model for system case management to: <ul style="list-style-type: none"> <li>ensure the right services are provided at the right time</li> <li>enhance disease-specific knowledge and expertise of involved providers</li> <li>promote continuity and coordination of care as individuals move from one part of the health system to another.</li> </ul>	All individuals with ALS and Primary Lateral Sclerosis (PLS) living within the Calgary city limits.
Median time from onset of symptoms until death is 23 – 48 months. Short life expectancy combined with rapidly changing complex needs of the client and family require an effective timely and coordinated response to care <sup>2</sup>			
Locally, service gaps previously identified and documented start at time of diagnosis and range from lack of support/education for patients/families to timely access to knowledgeable and skilled service providers. These issues were acknowledged in all care settings from Home Care to acute care, long term care and hospice and continue to exist today. <sup>3</sup>	<b>Resources</b>	<b>Risks</b>	<b>Model</b>
In 2005, the Calgary Health Region (CHR) ALS Clinic served 123 clients. Statistics indicate 50% of clients were transitioned from one location of care to another during their final phase of life. The impact upon service providers and clients/families is profound. A consistent theme is lack of coordination and continuity of care. <sup>4</sup>	Alberta Health and Wellness (AHW) <i>Continuing Care Initiatives Grant for System Case Management</i>	Limited resources – 1.0 FTE's	Case Manager with professional background and ALS/PLS expertise
Because the number of clients and families affected by ALS is relatively small, few clinicians encounter the disease with a frequency that fosters expertise.	AHW Continuing Care Leaders Council <i>Case Management for Continuing Care Clients</i>	Potential for role confusion and duplication	Combination of Shared Care and Strengths-based Case Management Models with focus on 2 key functions: <ul style="list-style-type: none"> <li>system navigation</li> <li>clinical consultation</li> </ul>
	System-wide Case Management Steering Committee	System service issues: limited disease-specific experience of existing services, scarce resources – particularly related to long term care options	Consultation may occur in any or all of the following formats <sup>5</sup> : <ul style="list-style-type: none"> <li>Client-centred</li> <li>Consultee-centred case</li> <li>Program-centred administrative</li> <li>Consultee-centred administrative</li> </ul>
	Cross-sector Working Group		
	Existing Information Systems, Technology and Space		
	<b>Background</b>	<b>Desired Impact</b>	
	“Case Management is a collaborative, client-driven strategy for the provision of quality health and support services through effective and efficient use of resources to support the client’s achievement of their goals.” ( <i>CHR Framework for Case Management 2004</i> )	Enhanced client and family self-care.	Adhere to evidence-based case management practice: client-driven, goal-directed, engaging the right resources at the right time
		Sustained client/family participation in meaningful roles.	
		Improved consistency of clinical care and practice.	
		Appropriate utilization of limited resources.	System service issues are tracked and reported

<sup>1</sup> Simmons, Z. *Management strategies for patients with amyotrophic lateral sclerosis from diagnosis through death.* **The Neurologist** 2005; 11: 257-270.

<sup>2</sup> Ibid

<sup>3</sup> Calgary Health Region. *Palliative Care for Persons with ALS: Summary of Key Variances*, June 2004.

<sup>4</sup> Calgary Health Region. *Case Management for the ALS Population*. Revised by A Lennox. January 2008.

<sup>5</sup> Ibid

## Appendix IV

### Amyotrophic Lateral Sclerosis System-wide Case Management Logic Model - Revised

Main Components	Referral Screening/Triage	Engagement/Assessment	Goal Setting/Care Planning	Interventions	Monitoring/Evaluation	Transition
Implementation Objectives	To ensure referred clients meet inclusion criteria. To triage referrals based on urgency. To recommend alternatives when inclusion criteria not met	To initiate a therapeutic relationship To integrate and build upon existing assessment information To understand client strengths/challenges and priorities To communicate findings to others involved in care.	To support clients/families to set achievable goals. To plan effective interventions to meet these goals. To clarify roles of multiple providers and services.	To facilitate client/family access to the right service at the right time. To problem solve and advocate when what is needed is not available.	To monitor effectiveness of interventions and progress toward goals To provide evidence of contextual issues which are creating barriers	To identify and prepare for movement between care streams
Implementation Strategies	Referral Form and Process Map guide referral and triage activities. Inform/educate referral sources re: service	Assessment Template and Process Map guide assessment activities and negotiation of priorities Incorporate evidence-based practice findings	Collaborative care plan is developed, documented and communicated according to Process Map Incorporate evidence-based practice findings	Reinforce documented care plan as needed.	Expect changes and challenges Initiate proactive follow up and problem solving	Proactively educate clients, families and involved providers about disease progression and care options Recognize transitions in care are triggers for reassessment and adjustment of care plan
Outputs	# of referrals by source # of referrals accepted to service Satisfaction of client/caregivers and clinicians with process	Completed Assessment Templates Client/family demographics Themes/trends to assessed needs and negotiated priorities in relation to known key variances <sup>1</sup>	Documented care plans	Themes/trends to referrals and linkages made Evidence of system navigation and clinical consultation <sup>2</sup>	Themes/trends to changes and challenges Service gaps identified and documented	Themes/trends to transitions Updated care plans reflect introduction of new care partners
Short-Term Outcomes (1 year)	Identification of gaps for clients not accepted	Clients and caregivers understand their own needs Clients and caregivers negotiate with case manager to set priorities in the context of available resources	Clients have one plan of care across involved programs and services Others involved in care have access to disease-specific and system-level expertise	Care plans are implemented Others involved in care have access to disease-specific and system-level expertise	Care plans are adjusted as needed	Qualitative feedback identifies key factors related to successful transitions.
Long-Term Outcomes (2-3 years)	Client and caregiver self-management is optimized.		Client and caregiver participation in meaningful roles is enabled.		Communication and coordination between the client, caregiver, involved services, programs and resources is improved.	
Impact (3-5 years)	Existing services have increased capacity to meet the needs of individuals and families affected by Amyotrophic Lateral Sclerosis and Primary Lateral Sclerosis.					

<sup>1</sup> Calgary Health Region. *Palliative Care for Persons with ALS: Summary of Key Variances*, June 2004.

<sup>2</sup> Calgary Health Region. *Case Management for the ALS Population*. Revised by A Lennox January 2008.

## Appendix V

### Multiple Sclerosis System-wide Case Management Planning Framework - Revised

Issues	Client Needs	Strategies	Target Population
<p>MS is a chronic, progressive, prevalent condition with an unpredictable course</p> <ul style="list-style-type: none"><li>3000 Calgarians have MS</li><li>300 receive Home Care services (including Personal Care Home)</li><li>Another 120 reside in Care Centres<sup>1</sup></li></ul> <p>Multiple services/resources provide care but no single service is responsible for all aspects of disease over time</p> <p>Many clients successfully self-navigate – their functional impairments tend to be minimal and family support capable, available and willing</p> <p>Long-term Home Care clients and Care Center residents have a designated individual(s) to assess/monitor needs and coordinate services</p> <p>Multiple factors - including complexity of health care system, high prevalence of cognitive changes &amp; psychosocial challenges - impact self-management and problem solving</p> <p>Those without stable family supports or consistent ongoing connection to the system can experience difficulty getting to the right service at the right time</p> <p>Issues left unaddressed precipitate increased physical and mental health risks for the client and the individuals they are connected to and, over time, increase the likelihood of urgent Home Care admission or Urgent Care/Emergency/Acute Care encounters</p>	<p>At-risk clients and families require an individually planned, well integrated and coordinated combination of services and resources that extend across the health continuum and include other governmental and community services<sup>2</sup>.</p>	<p>Develop, implement and evaluate a model for system case management to:</p> <ul style="list-style-type: none"><li>connect MS clients and families to the health system</li><li>ensure the right services are provided at the right time</li><li>provide seamless care to MS clients as they move from one part of the health system to another.</li></ul> <p>Maximize client/family/system capacity via inclusion of Chronic Care Model concepts: organization of healthcare, community linkages, self-management support, delivery system design, decision support through clinical guidelines, and clinical information systems<sup>3</sup></p>	<p>Individuals not consistently connected to the health care system and experiencing challenges with self-care.</p>
	Resources	Risks	Model
	<p>Alberta Health and Wellness (AHW) <i>Continuing Care Initiatives Grant for System Case Management</i></p> <p>AHW Continuing Care Leaders Council <i>Case Management for Continuing Care Clients</i></p> <p>System-wide Case Management Steering Committee</p> <p>Cross-sector Working Group</p> <p>Existing Information Systems, Technology and Space</p>	<p>Large MS population – unclear how many are truly “at risk” and require system-wide case management</p> <p>Limited resources – 2.0 FTE’s</p> <p>Potential for role confusion and duplication</p> <p>System service issues: limited capacity of existing services, scarce resources, limited understanding of population needs</p>	<p>Case Managers with professional backgrounds and MS expertise</p> <p>Combination of Expanded Chronic Care, Integrated Care and Strengths-based Case Management models</p> <p>Adhere to evidence-based case management practice: client-driven, goal-directed, engaging the right resources at the right time</p> <p>High caseloads (150 – 200)</p>
	Background	Desired Impact	<p>Low intensity case management to provide monitoring, periodic consultation, and facilitate navigation between programs and services</p> <p>System service issues are tracked and Reported</p>
	<p>“Case Management is a collaborative, client-driven strategy for the provision of quality health and support services through effective and efficient use of resources to support the client’s achievement of their goals.” (CHR Framework for Case Management 2004)</p>	<p>Enhanced client and family self-care.</p> <p>Sustained client/family participation in meaningful roles.</p> <p>Improved consistency of clinical care and practice.</p> <p>Appropriate utilization of limited resources.</p>	

<sup>1</sup> *Multiple Sclerosis: A profile of clients and review of services provided by Home Care and Supported Living. Calgary Health Region. 2007.*

<sup>2</sup> Ibid

<sup>3</sup> Schaefer, BA, MPH; Davis, Connie, MN, ARNP. *Case Management and the Chronic Care Model: A Multidisciplinary Role. Lippincotts Case Management*, Volume 9(2). March/April 2004. 96–103.

## Appendix VI

### Multiple Sclerosis System-wide Case Management Logic Model - Revised

Main Components	Referral Screening/Triage	Consultation	Engagement/Assessment	Goal Setting/Care Planning	Interventions	Monitoring/Evaluation	Transition
Implementation Objectives	To ensure referred clients meet inclusion criteria. To triage referrals based on urgency. To recommend alternatives when inclusion criteria not met (see Consultation).	To share system-level insight and disease-specific knowledge with existing services and involved providers	To initiate a therapeutic relationship To integrate and build upon existing assessment information To understand client strengths/challenges and priorities To communicate findings to others involved in care.	To support clients/families to set achievable goals. To plan effective interventions to meet these goals. To clarify roles of multiple providers and services.	To facilitate client/family access to the right service at the right time. To problem solve and advocate when what is needed is not available.	To monitor effectiveness of interventions and progress toward goals To provide evidence of contextual issues which are creating barriers	To identify and prepare for movement between care streams
Implementation Strategies	Referral Form and Process Map guide referral and triage activities. Inform/educate referral sources re: service	Collaborative discussion Case reviews Joint visits Problem-solving Incorporate evidence-based practice findings	Assessment Template and Process Map guide assessment activities and negotiation of priorities Incorporate evidence-based practice findings	Collaborative care plan is developed, documented and communicated according to Process Map Incorporate evidence-based practice findings	Reinforce documented care plan as needed.	Expect changes and challenges Initiate proactive follow up and problem solving	Proactively educate clients, families and involved providers about disease progression and care options
Outputs	# of referrals by source # of referrals accepted to service Satisfaction of client/caregivers and clinicians with process	Narrative documentation CCIS Activity Recording Feedback from involved services and providers	Completed Assessment Templates Client/family demographics Themes/trends to assessed needs and negotiated priorities are reported with reference to MS Profile and Review*	Documented care plans	Themes/trends to referrals and linkages made Evidence of system navigation with reference to MS Profile and Review	Themes/trends to changes and challenges Service gaps identified and documented	Themes/trends to transitions
Short-Term Outcomes (1 year)	Refinement of referral process/criteria Creation of profiles of type of clients referred by various service areas Identification of gaps for clients not accepted	Clinicians report improved understanding of disease process and spectrum of programs and services	Clients and caregivers understand their own needs Clients and caregivers negotiate with case manager to set priorities in the context of available resources	Clients have one plan of care across involved programs and services	Care plans are implemented	Care plans are adjusted as needed	Qualitative feedback identifies key factors related to successful transitions.
Long-Term Outcomes (2-3 years)	Client and caregiver self-management is optimized.		Client and caregiver participation in meaningful roles is enabled.		Communication and coordination between the client, caregiver, involved services, programs and resources is improved.		
Impact (3-5 years)	Existing services have increased capacity to meet the needs of individuals and families affected by Multiple Sclerosis.						

\* Multiple Sclerosis: A profile and review of services provided by Home Care and Supported Living. Calgary Health Region. 2007.

## Appendix VII

### Brain Injury and Mental Health System-wide Case Management Planning Framework- Revised

Issues	Client Needs	Strategies	Target Population
<p>Transition Services utilizes the Pathways Information System to match profiles of assessed and approved individuals to vacancies in Personal Care Home (PCH), Designated Assisted Living (DAL) and Care Centre environments</p> <p>In addition to other reasons, some patient profiles will not match to available vacancies due to:</p> <ul style="list-style-type: none"> <li>• Age (under 65)</li> <li>• High psychosocial/behavioral needs</li> <li>• Complex family dynamics</li> </ul> <p>These individuals require a managed match and are placed on a Complex Client List. Managed matches are facilitated by the Transition Services – Regional Manager.</p> <ul style="list-style-type: none"> <li>• Census has been approximately 110 individuals for the past year</li> <li>• 50 are under 65 years of age</li> <li>• 37 of the 50 have Brain Injury or Mental Health diagnoses requiring additional cognitive, psychosocial and behavioral supports</li> </ul> <p>Cognitive, psychosocial and behavioral needs are difficult to accurately determine in acute/sub-acute care and increase in response to changes in setting, caregivers, and routines</p> <p>Services and resources to support the under 65 population in PCH, DAL and Care Centre environments are very limited</p> <p>When these admissions fail, individuals are transferred to Emergency or Acute Care and the Assessment and Approval process and lengthy waiting begins again</p>	<p>These clients and families require additional effort and expertise to identify, prepare for and sustain suitable long term care admissions.</p>	<p>Develop, implement and evaluate a model for system case management to:</p> <ul style="list-style-type: none"> <li>• provide seamless care to clients as they move from one part of the health system to another</li> <li>• engage services and resources to enable successful long term care admissions in this target population</li> <li>• identify service gaps.</li> </ul>	<p>Individuals with Brain Injury or Mental Health diagnoses assessed to require PCH, DAL or Care Centre admission – includes those individuals returning to Calgary Zone from Halvar Jonson Centre. .</p>
	Resources	Risks	Model
	<p>Calgary Health Region (CHR) 2004 <i>Framework for Case Management</i></p> <p>Alberta Health and Wellness (AHW) <i>Continuing Care Initiatives Grant for System Case Management</i></p> <p>AHW Continuing Care Leaders Council <i>Case Management for Continuing Care Clients</i></p> <p>System-wide Case Management Steering Committee</p> <p>Cross-sector Working Group</p> <p>Existing Information Systems, Technology and Space</p>	<p>Limited resources – 1.2 FTE's</p> <p>Potential for role confusion and duplication</p> <p>System service issues:</p> <ul style="list-style-type: none"> <li>• limited bed capacity in both acute and Continuing Care environments</li> <li>• limited understanding of cognitive, behavioral and psychosocial needs and interventions</li> <li>• limited resources to address cognitive, behavioral and psychosocial challenges for under 65 population in Continuing Care stream</li> </ul>	<p>Case Managers with professional backgrounds and Brain Injury and Mental Health expertise</p> <p>Combination of Integrated Care and Strengths-based Case Management models with shift to Intensive Case Management during episodes of client instability</p> <p>Adhere to evidence-based case management practice: client-driven, goal-directed, engaging the right resources at the right time</p> <p>Individuals are forwarded to Transition Services Regional Manager as per Complex Client Algorithm and triaged to Case Managers as appropriate</p> <p>System issues are tracked and reported</p>
	Background	Desired Impact	
	<p>“Case Management is a collaborative, client-driven strategy for the provision of quality health and support services through effective and efficient use of resources to support the client’s achievement of their goals.” (CHR Framework for Case Management 2004)</p>	<p>Reduction in failed long term care admissions due to difficult-to-manage client behaviors.</p> <p>Improved consistency of clinical care and practice through provision of disease-specific and system-level insight and information.</p> <p>Appropriate utilization of limited resources through facilitation of communication/coordination between client, caregiver and involved services, programs and resources.</p>	

## Appendix VIII

### Brain Injury and Mental Health System-wide Case Management Logic Model - Revised

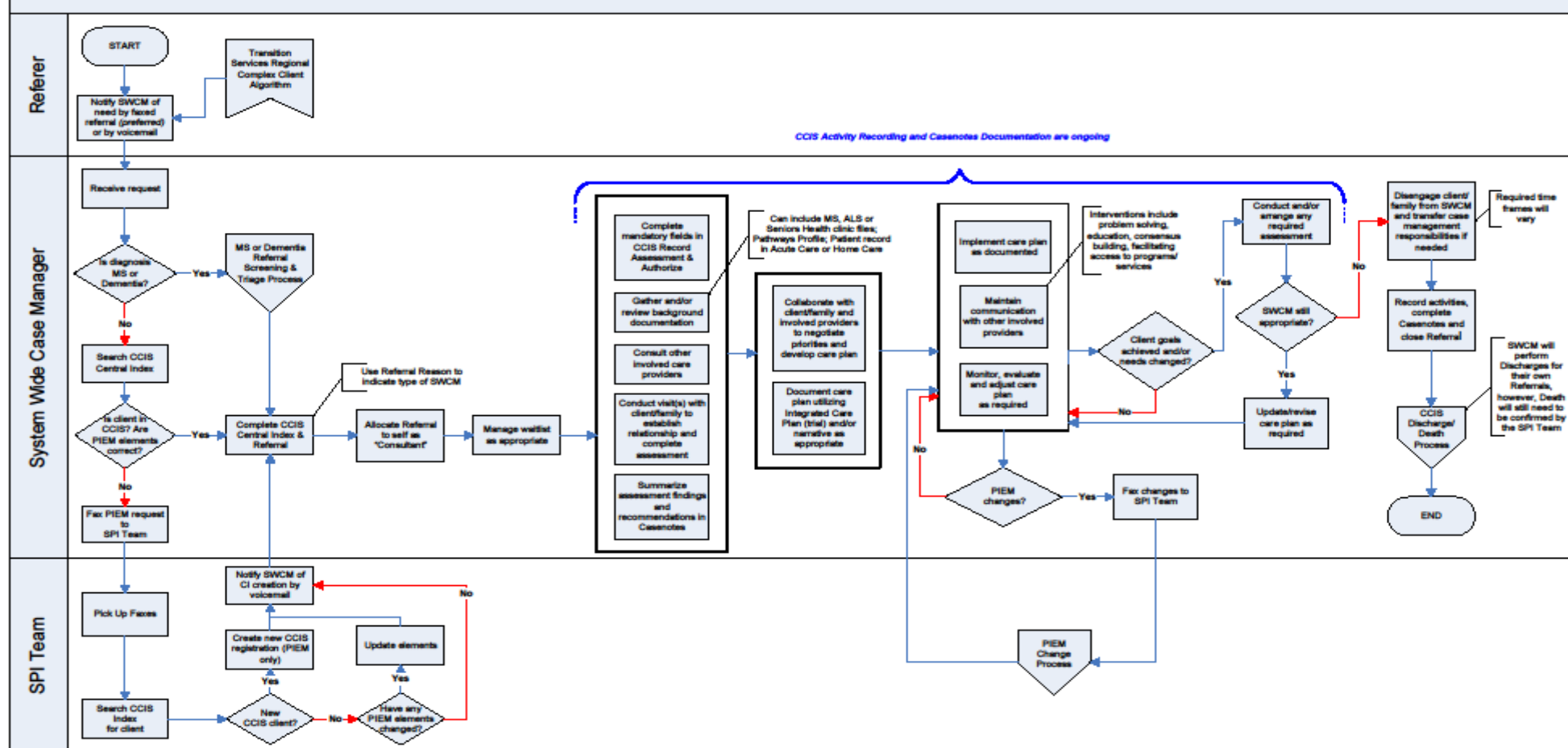
Main Components	Referral Screening/Triage	Engagement/Assessment	Goal Setting/Care Planning	Interventions	Monitoring/Evaluation	Transition
Implementation Objectives	To ensure referred clients meet inclusion criteria. To triage referrals based on urgency. To recommend alternatives when inclusion criteria not met	To initiate a therapeutic relationship To integrate and build upon existing assessment information To understand client and caregiver strengths, challenges and priorities To communicate findings to others involved in care.	To support planning of successful and seamless transitions To set achievable goals and identify effective interventions to meet these goals. To clarify roles of multiple providers and services.	To provide system-level insight and disease-specific knowledge To facilitate client/family access to the right service at the right time. To problem solve and advocate when what is needed is not available.	To monitor effectiveness of interventions and progress toward goals To provide evidence of contextual issues which are creating barriers	To identify and prepare for movement between care streams
Implementation Strategies	Transition Services Complex Client Algorithm guides referral and triage activities. Inform/educate referral sources re: service	Assessment Template and Process Map guide assessment activities and negotiation of priorities Incorporate evidence-based practice findings	Collaborative plans of action are developed, documented and communicated according to Process Map Incorporate evidence-based practice findings	Collaborative discussion Problem-solving Reinforce documented care plan as needed.	Expect changes and challenges Initiate proactive follow up and problem solving	Proactively educate clients, families and involved providers Anticipate increased care needs at times of transition and plan accordingly
Outputs	# of referrals by source # of referrals accepted to service Satisfaction of clinicians with process	Completed Assessment Templates Client/family demographics Themes/trends to assessed needs and negotiated priorities	Documented care plans	Themes/trends to linkages made and services engaged Evidence of system navigation with respect to known barriers	Themes/trends to changes and challenges Service gaps identified and documented	Themes/trends to transitions
Short-Term Outcomes (1 year)	Refinement of referral process/criteria Identification of gaps for clients not accepted	Clients care needs are thoroughly and objectively assessed with special attention to cognitive, psychosocial and behavioral issues Families, when involved, understand assessed care needs and available resources	Clients are involved in decisions to full extent of their capabilities Clinicians report improved understanding of disease process and spectrum of programs and services Clients have one coordinated plan of care across involved programs and services	Care plans are implemented	Care plans are adjusted as needed	Qualitative feedback identifies key factors related to successful transitions.
Long-Term Outcomes (2-3 years)	Client participation in meaningful roles and activities is enabled and difficult-to-manage behaviors are prevented or reduced.			Communication and coordination between the client, caregiver, involved services, programs and resources is improved.		
Impact (3-5 years)	Existing services have increased capacity to meet the long-term care needs of individuals and families affected by Brain Injury and Mental Illness.					

## Appendix IX

### System-wide Case Management Business Process

#### System Wide Case Management Project – Case Management Business Process (all populations)

June 30, 2009  
- DRAFT - Version 0.1



## **Appendix X**

### **System-wide Case Management for Individuals with Early Dementia**

#### **SYSTEM-WIDE CASE MANAGEMENT SERVICE DELIVERY CRITERIA**

##### **Inclusion Criteria in Dementia**

Individuals, living within the Calgary city limits, with a recently diagnosed dementia and one or more of the following risk factors:

- medical comorbidities
- behaviors associated with Frontal Lobe or Lewy-Body dementias
- complex family dynamics including remarriage
- requires support to facilitate Advance Care Planning (ACP) decision-making
- requires access and coordination of multiple, ongoing services and programs.

##### **Exclusion Criteria in Dementia**

Individuals:

- receiving care coordination through the Integrated Home Care program
- residing in a Personal Care Home, Designated Assistive Living facility or care centre.

#### **SYSTEM-WIDE CASE MANAGEMENT FINDINGS**

##### **Individual and System Outcomes in Dementia**

The following case examples illustrate additional qualitative themes.

###### ***Clients and families continue to learn about the impact of disease***

*On the first visit between the System-wide Case Manager and Mr and Mrs H, Mr H was not agreeable to any services or education. While he acknowledged his wife was having memory problems he denied the diagnosis or any need for support. The couple was agreeable to periodic contact with the System-wide Case Manager. Over several months, Mr H was able to identify and talk about his wife's diagnosis. He became receptive to education and suggestions for support including participation in the Living with Dementia program.*

###### ***Clients and families are supported to adjust to changes and prepare for the future***

*Mrs N was embarrassed by her dementia-related expressive aphasia. She had gradually withdrawn from all of her previous activities. She now socialized exclusively with her family and rarely left her home. The System-wide Case Manager convinced her to attend the Memory P.L.U.S. program. Mrs N greatly enjoyed this. Although the program has finished, she continues to get together with the group once a month. She and her family realize they are not alone in living with this disease and are pursuing other opportunities for interaction.*

###### ***Clients and families prepare for the future***

*Mr F was diagnosed with a dementia. Mrs F was the primary caregiver and herself battling cancer. Through an initial assessment, the System-wide Case Manager recognized Mr and Mrs F were struggling to complete their Personal Directives. Exploration revealed that their adult children, who ultimately would be their Agents, had differing beliefs and values concerning healthcare. The System-wide Case Manager met with the children to provide information and clarification of what Mr and Mrs F wanted. Mr and Mrs F were able to complete their Personal Directives. Mrs F acknowledged it brought her peace of mind to have this process completed.*

### ***Collaborative practice and knowledge exchange are supported***

*Mr S has a recent diagnosis of a dementia and is referred to the System-wide Case Manager by a physician at a day hospital program. The System-wide Case Manager contacts Mrs S and is told that Mr S is going to be discharged from the day hospital program and is “on a list for something else”. Mrs S is unsure of any further details. Mrs S indicates that the couple’s primary concern is Mr S’s poor mobility and in particular his difficulty with the stairs at the entrance to their home. The System-wide Case Manager arranges a home visit and in the meantime contacts the day hospital program to clarify their involvement. The day hospital staff identify they are unaware of the referral to System-wide Case Management and have referred Mr S to the Integrated Home Care program, an Adult Day Support Program, and the Accessible Housing Society. The System-wide Case Manager’s interview with Mr and Mrs S confirms that Mrs S is coping well with Mr S’s cognitive impairments. Mrs S reveals she recently declined services and supports offered by the Integrated Home Care program and has not contacted the Accessible Housing Society because she cannot afford their fee and would need to arrange modifications herself anyway. Mrs S acknowledges she feels overwhelmed by the number of professionals and programs now involved. Over the course of the interview, the System-wide Case Manager and Mr and Mrs S agree that Personal Directives, Mr S’s mobility, and future respite care are the couple’s current priorities. The System-wide Case Manager clarifies she will follow up with the day hospital, the Integrated Home Care program and the Accessible Housing Society. In doing so, the System-wide Case Manager collaborates with the day hospital staff to refer Mr S to a falls program, clarifies the Accessible Housing Society fee is waivable and additional assistance to apply for funding and locate trades people is available; and negotiates a follow up visit and reassessment by the Integrated Home Care program with a focus on relationship-building and caregiver self-care. The System-wide Case Manager assists Mr and Mrs S to complete their Personal Directives and coordinates the involvement of the Falls Program and the Accessible Housing Society, and then hands off to the Community Care Coordinator.*

### ***Access is improved***

*As described above, on initial referral to the Integrated Home Care program, Mrs S denies that she requires any assistance to care for her husband. The System-wide Case Manager, aware that Mrs S is physically assisting Mr S with all of his daily routines, is able to follow up on previous conversations with Mrs S and reinforce that the services and supports are intended to maintain Mr S at home with her. The System-wide Case Manager contacts the Community Care Coordinator (CCC) who made the initial visit and advocates for a follow up visit and reassessment. The System-wide Case Manager is able to provide background information that Mrs S tends to minimize the amount of assistance she provides to her husband but is worried about being able to continue to care for him. The CCC agrees to go back with a focus on building a relationship with Mrs S. The CCC eventually arranges companion care for Mr S in his own home as a source of respite for Mrs S. The success of this respite care enables Mrs S to later accept assistance with Mr S’s personal care.*

### ***Informal resources are used effectively***

*Mrs T has a moderate stage dementia and is unsafe alone. Her primary caregiver is Mr T. The System-wide Case Manager's initial assessment reveals that Mr and Mrs T have become estranged from their adult daughter who lives in Calgary. Mr T is unclear as to why the relationship has broken down. Mr T is scheduled for surgery in a few months requiring 4 to 5 days in acute care. Mr T is concerned that his wife will require Integrated Home Care assistance and/or respite care to ensure her safety while he is in hospital. Over the next several months, the System-wide Case Manager facilitates gradual reconnection between the couple and their daughter, including support for the daughter to understand her mother's behaviors. By the time Mr T needs to go to hospital, the daughter is willing and able to stay with Mrs T.*

### ***Formal resources are used effectively***

*Mr G and his wife were involved with the System-wide Case Manager for several months and Mr G was referred to an Adult Day Support Program. In a scheduled follow-up appointment with a geriatrician at the Seniors Health Clinic, Mrs G assures the geriatrician that "everything is fine" and medication is adjusted as per clinical guidelines. Over several follow up phone calls, the System-wide Case Manager recognizes that Mr G is experiencing aggressive episodes. Mrs G is increasingly fearful of him and shares that the Adult Day Support Program application has been denied. Mrs G eventually discloses to the System-wide Case Manager that Mr G uses alcohol regularly. The System-wide Case Manager informs the geriatrician and medications are adjusted. Mr G's aggressive episodes decrease and the couple is successfully referred to the Dealing with Dementia program.*

### ***System gaps and barriers are acknowledged***

*The System-wide Case Managers' perspectives highlighted several previously known gaps and barriers*

- *Engaging family physicians and supporting their practice, particularly with respect to dementia diagnosis*
- *Gaps in Advance Care Planning*
- *Flexible respite options*
- *Transportation*
- *In-home mental health supports for under-65 population*
- *Inadequate resources to manage behavioral crises in community*
- *Deconditioning in hospital due to clinical and environmental limitations*
- *Inconsistent caregiver education and support across the Integrated Home Care program*

*These previously identified gaps and barriers still exist and need to be addressed.*

## **RECOMMENDATIONS**

### **1. Operationalize System-wide Case Management for individuals with an early dementia**

It is recommended that this role be operationalized with the following considerations:

#### *Target Population*

The experience of the System-wide Case Management project clarified the risk indicators for this target population:

- medical comorbidities
- behaviors associated with Frontal Lobe or Lewy-Body dementias
- second marriages with complex family dynamics
- support required to facilitate ACP decision-making
- individuals needing to access multiple, ongoing services and programs.

If it is required to manage the workload with a 1.0 full-time equivalent, it is recommended that referrals sources be refined to Calgary Zone Integrated Seniors Health clinics and formal Primary Care Network (PCN) partnerships. This would ensure that individuals have:

- a thorough medical assessment
- a confirmed diagnosis of a dementia
- a degree of complexity that warrants System-wide Case Management involvement
- a physician and/or specialist for clinical support.

It is recommended that individuals with these risk factors be referred to the System-wide Case Managers as early as possible. Service can be low-intensity and preventive until needs dictate otherwise.

#### *Service Delivery Model*

- The combination of strengths-based (Fast and Chapin, 2000) and integrated care (McGeehan and Applebaum, 2007) case management models is effective for this population.
- Case Management responsibilities should continue to be fully transitioned to direct service providers in the Integrated Home Care or Integrated Supportive & Facility Living programs as those levels of care become necessary. A brief period of overlap is recommended.

#### *Supervision and Support*

- The experience of the System-wide Case Management project confirmed that this approach requires a participatory style of supervision to support advocacy efforts and promote collaborative practice across the care continuum (Calgary Health Region, 2004). Management must sanction the time required for System-wide Case Managers to build effective relationships and must be prepared to actively facilitate dialogue and problem-solving across traditional boundaries.

#### *Staffing*

- The experience of this project verified that System-wide Case Management requires a professional background. It is recommended that positions of this nature continue to be classified in both Nursing and Allied Health unions as each contributes a unique and valuable perspective.
- Disease-based expertise and community experience are required for these roles. Other desirable qualifications include demonstrated diplomacy, resiliency, critical thinking, flexibility and creativity, and comfort working autonomously with few similar roles to model or emulate.

*Tools and Infrastructure*

- A single point of entry for System-wide Case Management referrals via either Community Care Access or Integrated Seniors Health One-line Referral should be re-explored. System-wide Case Management processes then need to be finalized in alignment with the respective information system.
- The System-wide Case Management Assessment form requires formal approval as per AHS policies.
- The current care planning tool should also be revisited.
- Clarify System-wide Case Management practice with respect to Advance Care Planning.
- The System-wide Case Manager's primary professional relationships exist with the Integrated Seniors Health clinics. Co-location at either of these sites, with drop-down access at the other, is appropriate.
- Home visit criteria and guidelines should be finalized and parking that facilitates community mobility is advised.
- Dedicated desk, phone and computer access at a minimum of two-thirds of the System-wide Case Manager's full-time equivalent is recommended.
- Wireless connectivity for CCIS was inconsistent across the Calgary Zone during this project period. The utility of a laptop for point-in-time documentation should be re-evaluated.

*Caseload*

- The identification of a manageable caseload size remains an unanswered question in the case management literature. The Calgary Zone Integrated Home Care program is currently developing a tool which utilizes several parameters to evaluate the acuity of individual cases and the weight of a caseload. The transferability of the tool to System-wide Case Management practice should be explored.
- As of January 31, 2010 the active caseload for one Dementia System-wide Case Manager is equal to 85 individuals.

*Key performance indicators*

Key performance indicators for the service are required. Possibilities include:

- Emergency/urgent/acute care utilization
- Caregiver burden or self-efficacy
- Percentage of completed Goals of Care Designations

## **2. Continue to foster expertise and support collaborative practice in the care of individuals with a dementia**

### **a. Designate a core group of professionals within Integrated Home Care and Integrated Supportive & Facility Living to be responsible for case management of individuals with complex chronic conditions.**

- Historically, Community Care Coordinators have found caseloads consisting only of complex individuals are too great a burden. Strategies to provide caseload mix but maintain a case management focus are required.

### **b. Develop Case Management Quick Reference Guide specific to early dementia**

Given the prevalence of dementia, the care continuum must continue to build upon its understanding and clinical expertise. A centralized list of strategies and resources would be valuable to individuals with case management responsibilities for this population. Such a quick reference guide would facilitate proactive, consistent approaches and practice across the continuum of services and should include:

- basic case management principles
- reputable sources of clinical information
- available programs and resources within the Calgary Zone

- practical everyday strategies to enhance client care.

An inventory of existing evidence-based resources for professionals and clients is needed. It is essential to partner with Integrated Seniors Health, the Integrated Home Care program and the Alzheimer Society to understand efforts currently underway.

**c. Explore strategies to enhance communication along the Dementia service continuum**

Communication between direct service providers is inconsistent. Communication processes between Integrated Seniors Health clinics and the Integrated Home Care program are recommended.

**3. Continue partnerships with government ministries and community agencies to address specific gaps and barriers**

System gaps and barriers (listed above) impact the determinants of health and the continuum of existing health care services. The experiences of the System-wide Case Managers provide a valuable perspective upon unmet client needs. Management support is required to utilize these insights to inform ongoing efforts within AHS and between AHS, local and provincial chapters of the Alzheimer Society, and other provincial government ministries such as Alberta Seniors and Community Supports.

**a. Implement the First Link program in the Calgary Zone**

The National Division of the Alzheimer Society has successfully implemented the First Link program to provide education and support to individuals and caregivers when Alzheimer-type dementia is first diagnosed. Implementation of this program in the Calgary Zone would provide a cost-effective source of valuable information. Consultation with the provincial AHS dementia strategy unit is required to identify how to move forward.

## Appendix XI

### System-wide Case Management for Individuals with ALS

#### **SYSTEM-WIDE CASE MANAGEMENT SERVICE DELIVERY MODEL**

##### **Inclusion Criteria in ALS**

- Individuals, living within the Calgary city limits, with a diagnosis of ALS. Given the similarity of care needs and care continuum, individuals with Primary Lateral Sclerosis (PLS) were also accepted.
  - The ALS Clinic Facilitator and ALS Society Client Service Coordinator continue to be the primary supports for individuals living beyond the city limits. The System-wide Case Manager provides on-site education and support when needed.

#### **SYSTEM-WIDE CASE MANAGEMENT FINDINGS**

##### **Individual and System Outcomes in ALS**

The following case examples illustrate additional qualitative themes.

##### ***Clients and families continue to learn about the impact of disease***

*Mrs W and her husband are seen in an intake meeting with the core ALS Clinic team shortly after she receives her diagnosis. They have many questions about the disease and what to do next. Despite the unpredictability of the disease and the fact Mrs W has no mobility issues yet, Mr W is ready to start renovating their home to make it wheelchair accessible. The System-wide Case Manager arranges a home visit the following week to assess accessibility and support the family to plan appropriately. A small adaptation was suggested with a plan to revisit further renovations as Mrs W's needs change. Ongoing reinforcement of disease-related information continues to support timely and informed decision-making.*

##### ***Clients and families are supported to adjust to changes***

*Mrs L is having difficulty accepting her diagnosis. She is no longer able to work and spends long hours at home alone. She lives in a two storey home with her husband and children. She is unable to access or exit her home independently. Over time, the System-wide Case Manager develops a trusting relationship with Mrs L and explores how Mrs L might continue to participate in activities outside her home. This naturally leads to the need to consider a lift to improve accessibility and to further exploration of safety and independence in her home. The System-wide Case Manager initiates a referral to the ALS Society Equipment Loan program to arrange a site inspection for a lift. Mrs L and her family borrow a lift and utilize their own resources to arrange for the installation.*

***Collaborative practice and knowledge exchange are supported***

*Mr R has advanced ALS and uses a computer to communicate. He, his wife, their Community Care Coordinator and the System-wide Case Manager collaboratively determine that Mr R can no longer be cared for at home. The System-wide Case Manager consults with the Manager of the Transition Services-Community team and an urgent admission to a long term care facility is arranged. The System-wide Case Manager participates in a case conference with the facility physician and direct service providers, the family, and a representative of the Integrated Home Care program to initiate a care plan. Mr R's care needs are high and the System-wide Case Manager advocates for added care dollars to support Mr R's initial transition. The System-wide Case Manager provides ongoing formal and informal education and support to direct service providers and staff throughout his stay. The System-wide Case Manager remains involved with Mr R through to his end of life in the care centre. She actively acknowledges his written comments regarding his care and she supports communication of his wishes to facility staff and the Palliative Consultation Team.*

***Access is improved***

*Mrs K has advanced ALS. The System-wide Case Manager has attempted many Advance Care Planning discussions with Mrs K with little success. Mrs K is in acute care. The System-wide Case Manager, the Transitions Services Coordinator and the Palliative Consultation team collaboratively identify that long term hospice, although not a perfect choice is the best discharge option. Mrs K reluctantly agrees. The System-wide Case Manager provides education to the hospice staff and ensures all adaptive equipment is in place prior to Mrs K's admission. The hospice admission is highly stressful for Mrs K and the direct service providers for several weeks. On arrival, she is unhappy and refuses to sign paperwork associated with admission. The System-wide Case Manager remains consistently involved and eventually facilitates consensus that hospice remains the best place for Mrs K to receive the care she requires Continued System-wide Case Management interventions with Mrs K and the direct service providers allows Mrs K to remain at the hospice until her end of life several months later.*

*Learnings from experiences with Mrs K enable a much smoother long-term hospice admission for Mr S, another individual with advanced ALS in acute care some months later. The System-wide Case Manager again ensures adaptive equipment is in place at the hospice in advance and facilitates inclusion of the hospice team in a conference with Mr and Mrs S to complete admission paperwork prior to hospital discharge.*

***Resources are used effectively***

*Mrs G has advanced ALS and has been in acute care for several months. Transition Services, Integrated Home Care, and acute care professionals collaboratively determine that she can no longer be cared for at home as she now requires 2-person assistance for transfers. Long term care admission is not culturally acceptable to Mrs G and her extended family. The System-wide Case Manager's clinical expertise prompts reconsideration of a discharge home. The System-wide Case Manager completes a joint home visit with an Occupational Therapist from the Integrated Home Care program to assess Mrs G's lift and transfer needs. Day and weekend passes are arranged to assess lifts and transfers with private and contracted service providers. After many meetings, Mrs G's family negotiates with each other to share in Mrs G's care with the Integrated Home Care program - Palliative team. Mrs G has now been home with her son and extended family for many months.*

### *Alternative solutions are identified*

*Mr F has ALS and shares a specially modified home with his extended family. He is supported on the Integrated Home Care program through a combination of vendor and Self-managed Care. His care needs increase and family burnout becomes evident. Overnight live-in care becomes necessary. Mr F and his family are not receptive to the idea of a live-in caregiver and Mr F chooses to move to a Private Assisted Living facility. The System-wide Case Manager advocates for Mr F's vendor and Self-managed Care to continue in the Private Assisted Living facility in order to meet care needs. This combination of services and supports allows Mr F to remain in the Private Assisted Living facility through to his end of life.*

### *System gaps and barriers are acknowledged*

*The System-wide Case Manager's perspective highlighted several previously known gaps and barriers. The ALS System-wide Case Management Advisory Group, including the System-wide Case Manager, collaborated on three specific efforts related to the care of this population:*

- *A request for a Regional Ethics consultation regarding limited availability of supportive living options*
- *A request to revisit the Integrated Home Care program's policy to change contracted vendor agencies upon transfer between adult and palliative teams*
- *A half-day workshop led by Hospice Calgary to facilitate self-care building for professionals caring for individuals with ALS*

*Previously identified gaps and barriers, including flexible respite care and alternative supported and facility living options (Calgary Health Region, 2006) still exist and need to be addressed.*

## **RECOMMENDATIONS**

### **1. Operationalize System-wide Case Management for the ALS population**

It is recommended that this role be operationalized with the following considerations:

#### *Target Population*

- The experience of the project confirmed the value of connecting to individuals with ALS and PLS when the diagnosis is disclosed.
- Exploration of telehealth utilization could support further expansion in the Calgary Zone and beyond.

#### *Service Delivery Model*

- The combination of strengths-based (Fast and Chapin, 2000) and integrated care case management models (McGehean and Applebaum, 2007) is effective for this population.
- Primary case management responsibilities should continue to be transferred to direct service providers in the Integrated Home Care or Integrated Supportive & Facility Living programs as those levels of care become necessary. The System-wide Case Manager's ongoing involvement should be driven by the complexity of care needs and the clinical expertise of the case manager assuming responsibility.
- After hours or on call coverage remains a definite need and should be explored in consultation with key stakeholders.

#### *Supervision and Support*

- The experience of the project confirmed that this approach requires a participatory style of supervision to support advocacy efforts and promote collaborative practice across the care continuum (Calgary Health Region, 2004). Management must sanction the time required for System-wide Case Managers to build effective relationships and must be prepared to actively facilitate dialogue and problem-solving across traditional boundaries.

#### *Staffing*

- The experience of this project verified that System-wide Case Management requires a professional background. It is recommended that positions of this nature continue to be classified in both Nursing and Allied Health unions as each contributes a unique and valuable perspective.
- Disease-based expertise and community experience are required for this role. Other desirable qualifications include demonstrated diplomacy, resiliency, critical thinking, flexibility and creativity, and comfort working autonomously with few similar roles to model or emulate.

#### *Tools and Infrastructure*

- A single point of entry for System-wide Case Management referrals via Community Care Access is recommended. System-wide Case Management processes should then be finalized in alignment with CCIS.
- The System-wide Case Management Assessment form requires formal approval as per AHS policies.
- The current care planning tool should also be revisited.
- Clarify System-wide Case Management practice with respect to Advance Care Planning.
- The case manager's primary professional relationships exist with the ALS Clinic and the adult and palliative teams of the Integrated Home Care program. Co-location with any of these partners at a site that facilitates mobility across the continuum is appropriate.
- Dedicated desk, phone and computer access at a maximum of one-half of the System-wide Case Manager's full-time equivalent is recommended.
- A cell phone is required to support productivity during time out of the office.
- Wireless connectivity for CCIS was inconsistent across the Calgary Zone during this project period. The utility of a laptop for point-in-time documentation should be re-evaluated.

#### *Caseload*

- The identification of a manageable caseload size remains an unanswered question in the case management literature. The Calgary Zone Integrated Home Care program is currently developing a tool which utilizes several parameters to evaluate the acuity of individual cases and the weight of a caseload. The transferability of the tool to System-wide Case Management practice should be explored.
- As of January 31, 2010 the active caseload for one ALS System-wide Case Manager is equal to 63 individuals.

#### *Key performance indicators*

- Key performance indicators for the service are required. Possibilities include:
  - Emergency/Urgent/Acute care utilization
  - PHQ-9
  - Caregiver burden or self-efficacy

## **2. Continue to foster expertise and support collaborative practice in the care of individuals with ALS**

**a. Designate a core group of professionals within Integrated Home Care and Integrated Supportive & Facility Living to be responsible for case management of individuals with complex chronic conditions.**

- Historically, Community Care Coordinators have found caseloads consisting only of complex individuals are too great a burden. Strategies to provide caseload mix but maintain a case management focus are required.

**b. Develop a Case Management Quick Reference Guide specific to ALS**

A centralized list of strategies and resources would be valuable to individuals with case management responsibilities for this population. Such a quick reference guide would facilitate proactive, consistent approaches and practice across the continuum of services and should include:

- basic case management principles
- reputable sources of clinical information
- available programs and resources within the Calgary Zone
- practical everyday strategies to enhance client care.

An inventory of existing evidence-based resources for professionals and clients is needed. It is essential to partner with the ALS Clinic and the ALS Society to understand efforts currently underway.

**3. Continue to partner with government ministries and community agencies to address specific gaps and barriers**

System gaps and barriers (listed above) impact the determinants of health and the continuum of existing health care services. The experiences of the System-wide Case Manager provide a valuable perspective upon unmet needs within this population. Management support is required to utilize these insights to inform ongoing efforts within AHS and between AHS, the ALS Society, and other provincial government ministries including Alberta Seniors and Community Supports.

## **Appendix XII**

### **System-wide Case Management for Individuals with MS**

#### **SYSTEM WIDE CASE MANAGEMENT SERVICE DELIVERY**

##### **Inclusion Criteria in MS**

Individuals, living within the Calgary city limits, with a diagnosis of MS and on or more of the following risk factors:

- Co-morbidities in the individual *or* caregiver i.e. cancer, mental illness, addictions
- Parental responsibilities for young children
- Cognitive changes
- Presence of depression or anxiety
- A pattern of missed/cancelled appointments
- 18 – 25 years of age
- New immigrants
- Recent shift from relapsing/remitting to secondary progressive form of MS
- Feel the system has failed them
- Breakdown in formal & informal caregivers and family relationships
- Financial barriers.

##### **Exclusion Criteria in MS**

- Individuals receiving care coordination through the Integrated Home Care program are not formally admitted to this service. Client and system consultation are offered to the Community Care Coordinator.

#### **SYSTEM-WIDE CASE MANAGEMENT FINDINGS**

##### **Individual and System Outcomes in MS**

The following case examples illustrate additional qualitative themes.

##### ***Clients and families continue to learn about the impact of disease***

*Mr E was diagnosed with progressive MS 15 years ago. Although he is no longer employed and his interaction in the community is decreasing, he perceives he is successfully managing the symptoms of his disease. The System-wide Case Manager negotiates monthly contact via telephone. During one of their monthly calls, Mr E indicates he is urinating more frequently and his legs seem weaker. The System-wide Case Manager suggests Mr E may have a urinary tract infection. Mr E is unaware of the signs and symptoms of such an infection or of its common occurrence in MS. Mr E sees his family physician and the urinary tract infection is diagnosed and treated. The System-wide Case Manager also refers Mr E to the Registered Nurse at the Optimus Rehabilitation program for further education on MS and bladder care.*

***Clients and families are supported to adjust to changes***

*Ms P is a young woman with a relatively recent diagnosis of MS. She is married and has a 2 year old daughter at home. The Optimus program refers Ms P to the System-wide Case Manager as she has missed several appointments for Physical Therapy and to complete an application for Canada Pension Plan - Disability benefits. Over a series of home visits, the System-wide Case Manager identifies financial issues, child care and household management challenges, cognitive changes and a strained marital relationship. The System-wide Case Manager also recognizes that Ms P and her spouse are distressed by the term “disabled” and this is why they have not followed through with the benefit application. The System-wide Case Manager supports the couple to recognize the changes occurring and the assistance that is available. CPP-D benefits are obtained and the couple is able to afford a nearby day home for their daughter. The System-wide Case Manager facilitates a referral to the Integrated Home Care program and Ms P resumes her involvement in the Optimus program.*

***Collaborative practice and knowledge exchange are supported***

*Ms D is struggling with MS symptom management including fatigue, pain and cognitive changes. She also has a history of chronic anxiety and addictions. She reports an abusive upbringing, and lives alone, only recently in contact again with a sister by long distance. Consultation with the Integrated Home Care program Community Care Coordinator reveals that Ms D declines most medical interventions offered and has alienated several contracted care providers with her emotional outbursts and unusual requests. The System-wide Case Manager learns through the initial assessment that Ms D is feeling overwhelmed. She is facing imminent eviction and has made no other living arrangements. The System-wide Case Manager assists her to find and move to a new subsidized apartment. The System-wide Case Manager collaborates with the Community Care Coordinator to again arrange contracted care services and facilitates education of the contracted care providers. The System-wide Case Manager continues to advocate with adult Mental Health services to address Ms D’s mental health needs.*

***Access is improved***

*Ms I is a 54 year old Integrated Home Care program client with advanced MS. Her Community Care Coordinator consults with the System-wide Case Manager due to challenges addressing Ms I’s decreasing mobility and uncontrolled chronic pain. The System-wide Case Manager consults with the MS Clinic and facilitates a referral to the Community Accessible Rehabilitation program. Ms I receives Physical Therapy services and an orthoses. The CCC and System-wide Case Manager are also able to support Ms I to disclose a codeine addiction and work with other professionals to rotate her to non-opioid pain relief.*

***Informal resources are utilized effectively***

*Mrs B is 51 yrs old and has advanced secondary progressive MS. She lives at home with her husband and their 19 year old daughter. Mr B continues to work full-time outside the home and assists Mrs B with all of her personal care and mobility. The Community Care Coordinator consults the System-wide Case Manager regarding family distress and client coping. Over a series of discussions with Mrs B, the System-wide Case Manager facilitates Mrs B's acceptance of personal care assistance twice per week. The CCC is later able to increase this to daily assistance. The System-wide Case Manager is also establishes communication with Mr B and facilitates a meeting with the couple and the CCC. The group reaches a consensus to pursue a ceiling track system to for further assistance with lifts and transfers. Mr B acknowledges the value of the personal care services now in place. He feels less burdened and that he now has time to provide cognitive assistance and emotional support to his wife.*

***Formal resources are utilized effectively***

*Mrs C is 45 years old, married, with 2 young teens at home. She has had secondary progressive MS for over 10 years, requires a wheel chair for mobility and is cognitively intact. The Community Care Coordinator consults the System-wide Case Manager to assist with what has become a complex situation. The contracted care providers can no longer safely transfer Mrs C and a lift is required. Mr C is not returning the CCC's calls and does not appear to be following through on obtaining a lift. Over a series of visits, the System-wide Case Manager establishes communication with Mrs and Mr C and clarifies that both individuals wish for Mrs C to continue to live at home. Unfortunately, Mrs C develops a pressure wound and is admitted to acute care for treatment. The System-wide Case Manager maintains contact with Mrs C and learns from documentation that the plan is to discharge her to long term care. The System-wide Case Manager confirms that Mr and Mrs C are not in agreement with this plan and consults the Social Worker on the acute care unit. A care conference is arranged including the couple, the System-wide Case Manager, the Integrated Home Care program, Transition Services, the Regional Community Transition Program and the acute care team. The consensus is that Mrs C provides a vital parenting role to her children and she and her family want her to return home. The Integrated Home Care program confirms that her care needs can be met in the home with adaptive equipment in place and a plan to return home is established.*

***Alternative solutions are identified***

*Ms S is 55 years old and lives alone. She has advanced MS and a longstanding history of mental health issues with multiple suicide attempts. Ms S has one adult daughter but a difficult relationship with her. In exploring Ms S's plans for the future, the System-wide Case Manager establishes that the client is frustrated with her family physician. She finds it very difficult to access his office and does not feel he is listening to her concerns including pain, medications and end of life. The System-wide Case Manager assists Ms S to access telephone counseling support through her daughter's private health care plan and to identify a physician willing to visit her at home. Ms S receives appropriate pain medication and physician support to complete her Goals of Care Designation. Her stress levels are reduced and she has not attempted suicide in over 1 year.*

*System gaps and barriers are acknowledged*

*The System-wide Case Manager's perspective highlighted several previously known gaps and barriers (Calgary Health Region, 2006) including:*

- *Connecting to family physicians and supporting their practice*
- *Management of chronic pain*
- *Household management and parental supports*
- *In-home mental health supports for the under-65 population*
- *Flexible respite options*
- *Transportation*
- *Supportive and facility living options*

*These previously identified gaps and barriers still exist and need to be addressed.*

## **RECOMMENDATIONS**

### **1. Operationalize System-wide Case Management for this at-risk MS population**

It is recommended that these roles be operationalized with the following considerations:

#### *Target Population*

- The experience of the project confirmed the risk indicators as listed previously in this document.
- It is recommended that individuals with these risk factors be referred to the System-wide Case Managers as early as possible.

#### *Service Delivery Model*

- A combination of strengths-based (Fast and Chapin, 2000) and integrated care (McGeehan and Applebaum, 2007) case management models is effective for this population.
- Primary case management responsibilities should continue to be transferred to direct service providers in the Integrated Home Care or Integrated Supportive & Facility Living programs as those levels of care become necessary. The System-wide Case Manager's ongoing involvement should be driven by the complexity of care needs and the clinical expertise of the case manager assuming responsibility.

#### *Supervision and Support*

- The experience of the project confirmed that this approach requires a participatory style of supervision to support advocacy efforts and promote collaborative practice across the care continuum (Calgary Health Region, 2004). Management must sanction the time required for System-wide Case Managers to build effective relationships and must be prepared to actively facilitate dialogue and problem-solving across traditional boundaries.

#### *Staffing*

- The experience of this project verified that System-wide Case Management requires a professional background. It is recommended that positions of this nature continue to be classified in both Nursing and Allied Health unions as each contributes a unique and valuable perspective.
- Disease-based expertise and community experience are required for these roles. Other desirable qualifications include demonstrated diplomacy, resiliency, critical thinking, flexibility and creativity, and comfort working autonomously with few similar roles to model or emulate.

#### *Tools and Infrastructure*

- A single point of entry for System-wide Case Management referrals via Community Care Access or the MS Clinic is recommended. System-wide Case Management processes should then be finalized in alignment with the respective information system.
  - In particular, processes are required to accurately capture consultation time allocated to clients not formally admitted to System-wide Case Management.
- The System-wide Case Management Assessment form requires formal approval as per AHS policies.
- The current care planning tool should also be revisited.
- The System-wide Case Managers' primary professional relationships exist with the MS Clinic at Foothills Hospital and the Integrated Home Care program Adults East and West teams. Co-location with any of these programs, with drop-down access at the others, is appropriate. Parking that facilitates community mobility is required.
- Dedicated desk, phone and computer access at a minimum of half of the System-wide Case Managers' full-time equivalent is recommended.
- Cell phones are required to support productivity when out of the office.
- Wireless connectivity for CCIS was inconsistent across the Calgary Zone during this project period. The utility of a laptop for point-in-time documentation should be re-evaluated.

#### *Caseload*

- The identification of a manageable caseload size remains an unanswered question in the case management literature. The Calgary Zone Integrated Home Care program is currently developing a tool which utilizes several parameters to evaluate the acuity of individual cases and the weight of a caseload. The transferability of the tool to System-wide Case Management practice should be explored.
- As of January 31, 2010 the active caseload for each MS System-wide Case Manager is approximately 50 individuals.

#### *Key performance indicators*

Key performance indicators for the service are required. Possibilities include:

- Emergency/urgent/acute care utilization
- Caregiver burden or self-efficacy
- Patient Health Questionnaire (PHQ-9)
- Multiple Sclerosis Self-efficacy Scale (MSSE)
- MS Impact Scale (MSIS-29)

## **2. Continue to foster expertise and support collaborative practice in the care of individuals with MS**

### **a. Designate a core group of professionals within Integrated Home Care and Integrated Supportive & Facility Living to be responsible for case management of individuals with complex chronic conditions.**

- Historically, Community Care Coordinators have found caseloads consisting only of complex individuals are too great a burden. Strategies to provide caseload mix but maintain a case management focus are required.

**b. Develop a Case Management Quick Reference Guide specific to MS**

A centralized list of strategies and resources would be valuable to individuals with case management responsibilities for this population. Such a quick reference guide would facilitate proactive, consistent approaches and practice across the continuum of services and should include:

- basic case management principles
- reputable sources of clinical information
- available programs and resources within the Calgary Zone
- practical everyday strategies to enhance client care.

An inventory of existing evidence-based resources for professionals and clients is needed. It is essential to partner with the MS Clinic, OPTIMUS and the MS Society – Calgary Chapter to understand efforts currently underway.

**c. Explore strategies to enhance communication along the MS Service Continuum**

Communication between direct service providers is inconsistent. Communication processes between MS Clinic, Integrated Home Care, OPTIMUS and Community Accessible Rehabilitation (CAR) are recommended.

**d. Re-establish a networking forum for the MS Service Continuum**

A regularly scheduled, system-wide forum - similar to the Calgary Zone Brain Injury Program Networking Event in June 2009 and the ongoing Community Mental Health North and South Networking meetings could facilitate interprofessional relationships and knowledge exchange related to existing clinical guidelines, programs and resources. Consultation with key stakeholders is required to appreciate lessons previously learned.

**3. Continue to partner with government ministries and community agencies to address specific gaps and barriers**

System gaps and barriers (listed above) impact the determinants of health and the continuum of existing health care services. The experiences of the System-wide Case Managers provide a valuable perspective upon unmet client needs. Management support is required to utilize these insights to inform ongoing efforts within AHS, and between AHS, local and provincial chapters of the MS Society, and other provincial government ministries such as Alberta Seniors and Community Supports.

## Appendix XIII

### System-wide Case Management for Individuals with Brain Injuries or Mental Illness

#### SYSTEM-WIDE CASE MANAGEMENT SERVICE DELIVERY

##### **Inclusion Criteria in Brain Injury and Mental Health**

Individuals with a diagnosis of acquired brain injury or mental illness:

- in an urban acute care facility **and** requiring admission to a Personal Care Home, Designated Assisted Living facility, or care centre
- Or
- living within one of the above supportive or facility environments and facing discharge or eviction due to unmanageable behaviors and/or complex care needs.

#### SYSTEM-WIDE CASE MANAGEMENT FINDINGS

##### **Individual and System Outcomes in Brain Injury and Mental Health**

The following case examples illustrate additional qualitative themes.

##### *Clients and families participate in their care*

*Mr T is a 35 year old man with a severe acquired brain injury. He is currently participating in a long term rehabilitation program. The consensus of the rehabilitation team is that Mr T requires a supported living environment but his parents want to have him move home on discharge. The System-wide Case Manager facilitates a leave pass with Integrated Home Care program support for several days to the parents' home. The System-wide Case Manager meets with Mr T and his family during the leave pass to discuss different care options and the long term needs of both Mr T and his parents. After the leave pass and ongoing discussions, Mr T and his parents agree that a supported living environment is the best option to meet Mr T's care needs, allow his parents to be involved and supportive but still engage in their retirement plans.*

##### *Collaborative practice and knowledge exchange are supported*

*Mr M is a 46 year old man with a severe acquired brain injury. He is transferred from a lengthy stay in acute care to a secure dementia unit in a long term care facility. The care centre staff is apprehensive about how Mr M will fit in with their elderly dementia residents. The staff expresses concern to the System-wide Case Manager about Mr M's intimidating physical stature, his reclusive nature, and his lack of participation in meals or social activities. The System-wide Case Manager identifies and explains differences between brain injury behavior patterns and the dementia behavior patterns the staff are familiar with. This information facilitates staff discussion about how to meet Mr M's care needs in this environment and the staff identifies strategies they can implement easily into his and their routines. On follow up visits, the System-wide Case Manager observes that both Mr M and the staff are coping well.*

### ***Access is improved within the Calgary Zone***

*Mr J is a 52 year old man with a primary diagnosis of chronic Paranoid Schizophrenia. He has been waiting in acute care for 20 months for admission to a Designated Assisted Living facility. He is able to leave the unit independently and attends the Carnat Centre day program 4 days per week. Mr J continues to experience significant anxiety and ongoing paranoia. The System-wide Case Manager recommends that a Personal Care Home (PCH) may provide a more suitable long-term environment. The System-wide Case Manager consults with the PCH Team manager and Mr J is identified as a priority for the next suitable space. The System-wide Case Manager is notified when a space becomes available but by this time Mr J has been transferred to a rural site to await long term care due to urban acute care capacity. The PCH space is allocated to the next client on the list. The System-wide Case Manager initiates contact with the staff at the rural site. Mr J is having significant anxiety due to the disruption of his routine and inability to access the Carnat Center program. Over the next 2 weeks, the System-wide Case Manager advocates for the next suitable PCH space. She works with the Social Worker at the rural site to arrange for Mr J to travel back to Calgary to tour the PCH and, when he accepts, facilitates the admission. Mr J continues to reside in the PCH and is again attending the Carnat Center.*

### ***Additional Example of Improved Access***

*Mrs H is a 72 year old female with a primary diagnosis of chronic Schizophrenia with delusions and auditory hallucinations. She has been waiting in a Regional Community Transition Program (RCTP) bed at the Fanning Centre for admission to long term care for over 14 months. Public Guardianship has recently been transferred to Mrs H's son on a trial basis. He also has a psychiatric history but has been deemed capable of managing this role. The RCTP unit staff report Mrs H has been very stable for 12 months. She is very cooperative and quiet. She rarely has auditory hallucinations but has one persistent delusion that she is married to Elvis Presley and he is coming to pick her up. The System-wide Case Manager and the Transition Services Coordinator collaborate to update Mrs H's Pathways profile to reflect her status and clearly explain her delusion. After 4 months of the System-wide Case Manager advocating for Mrs H's admission to various care centres, one centre agrees to consider her. The System-wide Case Manager provides the care centre with detailed information on Mrs H's background and care needs and the care centre agrees to accept Mrs H. Mrs H's transition to care centre goes very smoothly. She settles in and adjusts quickly with minimal anxiety or upset. Mrs H's son however is very upset at the move as he thought his mother would remain at Fanning Centre permanently. He refuses to go in to the care centre to sign admission paperwork and wants his mother moved to a care centre closer to his part of the city. The System-wide Case Manager works with the care centre Social Worker to resolve the son's concerns and maintain Mrs H's admission.*

### ***Access is improved between Zones***

*Mrs Z is a 31 year old mother with a severe acquired brain injury. When she is discharged home to her family from acute care she requires total assistance with daily living activities. Over time, the Home Care Community Care Coordinator recognizes that Mrs Z is beginning to show some physical improvement. The Community Care Coordinator consults with the System-wide Case Manager together they put forward a referral for the Brain Injury Program at Halvar Jonson Centre in the Central Zone. Mrs Z is accepted to the program and a lengthy period of rehabilitation is anticipated. The System-wide Case Manager maintains contact with the rehabilitation program with the long term goal to return Mrs Z to her home community and her family.*

### ***Informal resources are used effectively***

*Mr D is a 38 year old man with a history of psychotic symptoms, predominantly paranoid delusions. He has longstanding vision and hearing impairments and recently, and suddenly, became completely deaf. He is brought to the emergency department by his parents due to threats of suicide, of killing his parents, and of burning the house down. Mr D is admitted to acute care with a diagnosis of Schizophrenia. During the course of this admission his diagnosis is changed to Adjustment Disorder. Further investigations reveal hearing aids are now ineffective for Mr D and cochlear implants unsuitable. The acute care psychiatric unit reports Mr D is extremely disruptive and difficult to manage. His behavior includes verbal abuse of staff, yelling, tantrums, and threats. Communication with Mr D is difficult and slow via writing and reading single words on a white board or enlarging font on his computer. The consensus of the unit staff and psychiatrist is that the only appropriate placement option is a locked unit in a long term care centre. The System-wide Case Manager is consulted by the Transition Services Coordinator to assist in identifying Mr D's care needs and facilitating a long term care admission. Long term care bed capacity is very limited at this time. The System-wide Case Manager initiates the involvement of the Canadian National Institute for the Blind and Mr D begins to learn Braille while still in acute care. The System-wide Case Manager also resources a private psychologist in the community who specializes with hearing and vision impaired individuals - helping them develop coping strategies and connecting them with appropriate specialized supports and resources. The System-wide Case Manager and the acute care unit Social Worker collaborate to arrange funding for the psychologist via Assured Income for the Severely Handicapped. The Psychologist agrees to conduct an assessment to identify Mr D's level of functioning and provide recommendations regarding potential resources, supports, and funding within the community. The ultimate goal is to provide counseling, tools, and supports to maximize Mr D's functioning and assist him to successfully transition into the community. The psychologist's impression is that long term care may not be required permanently.*

### ***Formal resources are use effectively***

*Ms A is a 52 year old Aboriginal woman with an acquired brain injury and a history of mental illness. She lives in a Personal Care Home. The System-wide Case Manager is contacted by the Home Care Community Care Coordinator because Ms A is frequently yelling in the care home. This behavior is distressing both the caregiver and the other residents. The System-wide Case Manager investigates and identifies that Ms A's yelling appears to be related to hallucinations. The System-wide Case Manager arranges a case review with a Psychiatrist who recommends medication changes and other diagnostics. This information is shared with the Home Care Community Care Coordinator who follows up with the Family Physician. The System-wide Case Manager also contacts the Aboriginal Mental Health program and Ms A is accepted for ongoing mental health support.*

### ***Alternative solutions are identified***

*Mr G is a 62 year old man with an acquired brain injury. He can no longer live alone due to significant cognitive deficits and psychosocial needs. He resides in a long term care facility having been discharged from several smaller settings. He is by far the youngest and most mobile of all the residents and neither he nor the care centre staff feels that he requires this level of care. The System-wide Case Manager periodically reaffirms Mr G's care needs and collaborates specifically with the Recreation Therapy staff. Mr G is supported to volunteer as an exercise lead, cook for the centre's weekly pancake breakfast, and participate in a fitness program for his age group at the local recreation centre. He remains the youngest resident in the care centre*

*but expresses positive feelings about what he is able to do there. The staff recognizes his care needs and values him as a productive person.*

### ***System gaps and barriers are acknowledged***

*System-wide Case Management is not a panacea for limited resources within the current continuum of care in the Calgary Zone. The System-wide Case Managers' perspective highlighted several previously known gaps and barriers (Calgary Health Region, 2005) including:*

- *Integration and coordination of care for these populations upstream of the point at which they require supported or facility living*
- *In-home mental health supports for the under-65 population*
- *Flexible respite options*
- *Suitable supported and facility living options.*

*These previously identified gaps and barriers still exist and need to be addressed.*

## **RECOMMENDATIONS**

### **1. Create System-wide Case Management Roles for at-risk Brain Injury and Mental Health Populations**

The potential exists to generalize the benefits found for the early dementia, ALS and MS populations to the Brain Injury and Mental Health populations. It is recommended that System-wide Case Management be available to a broader spectrum of individuals with these diagnoses at a much earlier stage in their disability. This recommendation is congruent with previous findings related to Brain Injury services (Calgary Health Region, 2005). The findings of this project should be integrated with further consultation with the Brain Injury and Mental Health care continuums to identify:

- *Target Populations*
- *Service Delivery Model*
- *Supervision and Support*
- *Staffing*
- *Tools and Infrastructure*
- *Caseload*
- *Key performance indicators*

### **2. Continue to foster expertise and support collaborative practice specific to both Brain Injury and Mental Health**

#### **a. Designate a core group of professionals within Integrated Home Care and Integrated Supportive & Facility Living to be responsible for case management of individuals with complex chronic conditions.**

- Historically, Community Care Coordinators have found caseloads consisting only of complex individuals are too great a burden. Strategies to provide caseload mix but maintain a case management focus are required.

#### **b. Develop a Case Management Quick Reference Guide specific to Brain Injury and one specific to Mental Illnesses commonly encountered within Continuing Care**

A centralized list of strategies and resources would be valuable to individuals with case management responsibilities for these populations. Such quick reference guides would facilitate proactive, consistent approaches and practice across the continuum of services and should include:

- basic case management principles
- reputable sources of clinical information
- available programs and resources within the Calgary Zone
- practical everyday strategies to enhance client care.

An inventory of existing evidence-based resources for professionals and clients is needed. It is essential to partner with key stakeholders for both populations to understand efforts currently underway.

**c. Establish an ongoing networking forum for the Brain Injury Continuum**

A regularly scheduled, system-wide forum - similar to the Calgary Zone Brain Injury Program Networking Event in June 2009 or the Mental Health North and South Network meetings – is recommended to:

- Facilitate relationship-building
- Exchange knowledge of existing clinical guidelines, programs and resources.

**d. Support strategies that strengthen relationships and communication between community Mental Health and Continuing Care**

**e. Create enhanced transition processes and environments for complex populations, specifically those under 65 years of age, within Continuing Care**

As of October 2009, this caseload included thirty individuals in acute care who require:

- A single room on a small unit
- Increased staff ratio including rehabilitation and recreation
- Staff with knowledge and experience in the care of individuals with brain injury and mental illness including behavior management approaches
- Age appropriate programs/activities.

Creation of such environments within Continuing Care in the Calgary Zone would facilitate successful, sustainable transitions for these individuals. It will also be important to ensure appropriate preparation of the client, family and placement facility. Documentation and communication of daily care plans/routines in advance of the client's transition is a critical piece of this preparation.

**f. Develop a Community Mental Health Consultation Team to support Adults under 65 in the Continuing Care stream**

Integrated Home Care and Integrated Supportive & Facility Living would benefit from access to a team of individuals with expertise in the management of complex cognitive and mental health issues in adults under the age of 65. This team should include a Psychiatrist and Mental Health and Rehabilitation professionals. Due to fluctuating functional and behavioral issues this team would need to be involved on an ongoing basis and provide education and support to direct service providers.

**3. Continue to partner with government ministries and community agencies to address specific gaps and barriers**

System gaps and barriers (listed above) impact the determinants of health and the continuum of existing health care services. The experiences of the System-wide Case Managers provide a valuable perspective upon unmet needs within these populations. Management support is required to utilize these insights to

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inform ongoing efforts between AHS streams of care, key stakeholders such as the Southern Alberta Brain Injury Society and the Canadian Mental Health Association, and other provincial government ministries such as Alberta Seniors and Community Supports.

## Appendix XIV

### System-wide Case Management Workload Measurement

#### Activity Recording Summary for February 2009 – October 2009

Client-specific Activity	Contact Method	Dementia		ALS (1.0 FTE)	MS		Brain Injury and Mental Health	
		Case Manager 1 (1.0 FTE)	Case Manager 2 (1.0 FTE)		Case Manager 1 (1.0 FTE)	Case Manager 2 (1.0 FTE)	Case Manager 1 (0.6 FTE)	Case Manager 2 (0.6 FTE)
Case Management (Client-specific)	Consultation	<b>14</b> (5-18)	<b>7</b> (4-13)	<b>5</b> (2-11)	<b>11</b> (3-22)	<b>16</b> (6-24)	<b>0</b> (0)	<b>22</b> (5-36)
	Documentation	<b>14</b> (10-21)	<b>16</b> (6-22)	<b>1</b> (1)	<b>8</b> (3-14)	<b>6</b> (1-21)	<b>5</b> (3-7)	<b>2</b> (1-5)
	Face to Face	<b>18</b> (12-29)	<b>16</b> (9-20)	<b>46</b> (21-65)	<b>21</b> (8-31)	<b>27</b> (10-39)	<b>16</b> (6-29)	<b>8</b> (1-22)
	Telephone	<b>20</b> (14-30)	<b>14</b> (8-21)	<b>2</b> (1-4)	<b>4</b> (1-10)	<b>19</b> (4-26)	<b>10</b> (5-16)	<b>0</b> (0)
<b>Client Non-specific Activity</b>								
Case Management (Group)		<b>29</b> (14-48)	<b>6</b> (2-12)	<b>55</b> (37-77)	<b>15</b> (4-23)	<b>14</b> (3-22)	<b>34</b> (20-48)	<b>69</b> (50-85)
Non-client Activity		<b>37</b> (22-47)	<b>3</b> (1-8)	<b>39</b> (4-78)	<b>54</b> (18-95)	<b>39</b> (21-67)	<b>36</b> (20-55)	<b>71</b> (50-103)
Travel		<b>20</b> (11-32)	<b>5</b> (3-7)	<b>55</b> (32-69)	<b>35</b> (12-56)	<b>27</b> (15-44)	<b>30</b> (16-48)	<b>54</b> (45-68)

Data reported in average # hours/month (range)

#### Definitions

##### *Case Management (Client-specific)*

Activities related to individual clients including referral screening, assessment, goal setting, care planning, intervention, monitoring and disengaging.

##### *Consultation*

Services provided on behalf of a specific client when service providers consult each other regarding the care of that client.

##### *Documentation*

Documentation completed on behalf of the client but not in the presence of the client/during the visit.

##### *Face to Face*

Services provided when the client/informal support system and case manager are in the same room.

##### *Telephone*

Services provided by the case manager to the client/informal support system via telephone.

##### *Case Management (Group)*

Activities not specific to individual clients including multidisciplinary rounds; relationship building; education given; advocacy; documenting gaps, unmet needs, duplication; removing barriers.

##### *Non-client Activity*

All non-patient activity including meetings, orientation, professional education. Any activity that can be considered Case Management (client-specific or group) is not included in this category.

##### *Travel*

Time spent driving to/from client visits and meetings.